State of Rhode Island

Department of Human Services

Center for Child and Family Health

Certification Standards

Providers of Home Based Therapeutic Services

February 5, 2003

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1.0 SERVICE INFORMATION AND BACKGROUND

1.1. Introduction

The Rhode Island Department of Human Services (DHS) is soliciting applications from qualified organizations to become certified as providers of Home Based Therapeutic Services (HBTS) for Medicaid eligible children with significant impairments in functioning. Children with special health care needs are those who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally. The establishment of this certification process and the issuance of these Certification Standards provide the basis for determination of provider-agencies eligible to receive payment for provision of HBTS.

To be a participating provider-agency of HBTS, interested parties including all new provider-agencies and current provider-agencies (i.e., provider-agencies providing HBTS on the date of issuance of these standards) will need to be certified by DHS as HBTS providers.

These Certification Standards further establish the procedures and requirements for HBTS services as administered by DHS and supercede all previous guidelines, verbal and written, issued by DHS regarding HBTS services.

Home Based Therapeutic Services require prior authorization. These standards describe the basis and mechanisms of prior authorization, as well for payment for services. Currently, there exist two paths for authorization of HBTS. These are directly through DHS or through a CEDARR Family Center. Provider-agencies are required to be certified by DHS to provide HBTS regardless of the path for the prior authorization (i.e., DHS or CEDARR Family Center).

Commencing January 1, 2003 all new requests for HBTS and their subsequent renewals will be managed by CEDARR Family Centers. DHS will, however, continue to provide clinical review and authorizations for HBTS plans that it currently oversees. At the discretion of DHS, CEDARR Family Centers will assume full responsibility for all HBTS authorizations in the future. In all cases families are free to select the certified HBTS agency of their choice.

These Certification Standards serve to provide families, potential applicants, service providers and other interested parties with a full description of Home Based Therapeutic Services, including guidance as to certification requirements and methods for application. Sections 1 through 5 contain service description and background as follows:

Section 1: Service Information and Background
Section 2: Certification Process
Section 3: Home Based Therapeutic Services
Section 4: Target Population and Location of Service Within the Continuum of Care
Section 5: Service Description – Required Scope of Services

Sections 1 provides an introduction to the service, Section 2 describes the process for certification and Section 3 contains a statement of the need for the service and the processes leading to development of these standards. Section 4 identifies the group of children that this service is expected to benefit and delineates how this service relates to the overall continuum of care. Section 5, Service Description, contains a detailed description of the service and identifies core requirements for the service.

The Certification Standards include two additional sections as follows:

Section 6: Requirements for Organization of Service Delivery – Performance Standards
Section 7: Qualified Entity Requirements

Sections 6 and Section 7 specifically describe the requirements for certification. Satisfactory compliance with these requirements must be demonstrated for certification; continuing compliance is required in order to maintain full certification status.

Certification applications will be primarily focused on Section 6. Although certified entities must comply with the requirements set forth in Section 7, the requirement to demonstrate such compliance in the application itself is more limited. Attachment A, Application Guide, provides more detailed instruction as to how to develop the certification application.

1.1.1 Home Based Therapeutic Services

HBTS are provided for children living at home (may also include children living with a foster family) who have been diagnosed with moderate to severe physical, developmental, behavioral or emotional conditions. These children have chronic health care needs that require health and related services beyond those required by children generally. Section 4.0 provides greater discussion about target populations and clinical appropriateness criteria.

HBTS can only be provided when there is medical necessity, as documented by a physician's prescription (See - Appendix 1: Definition of Medical Necessity), and documented evidence that HBTS can meet the needs of the child with special health care needs. These services require authorization from a CEDARR Family Center *(CFC)* or DHS. HBTS are more intensive than outpatient treatment but less restrictive than inpatient hospitalization or residential care.

Home Based Therapeutic Services are specialized health services delivered in a child's home and in community settings. They represent an integrated set of service components involving the provision of specialized treatment provided in accord with an approved individualized Treatment Plan with measurable goals and objectives. The Treatment Plan must be developed in consultation with a licensed health care professional[1]. Once approved by a CEDARR Family Center or DHS, the Treatment Plan is implemented by the HBTS provider-agency.

Absent a CEDARR referral for HBTS, the provider-agency must show it is working in collaboration and communication with all relevant parties (e.g., parents, school, medical home, psychiatric providers, and previous HBTS provider-agencies) in the development and implementation of services. Evidence of this collaboration must be referenced in the Treatment Plan.

An integrated HBTS Treatment Plan can include, in specified amounts as approved, the following reimbursable service components:

1.1.1.1 Clinical Supervision

Clinical supervision of the home-based worker is provided by a competent and licensed health care professional[2] to ensure effective implementation and oversight of the Treatment Plan. Overall, clinical supervision includes, but is not limited to, review and consultation on therapeutic methods used by the home-based worker, analysis of the child's response and progress and adjustments to the therapeutic regimen as appropriate. Greater specificity regarding clinical supervision can be found in Section 5.4.1. (See also: Appendix 4)

1.1.1.2 Home-Based Therapy Direct Services

There are two components of HBTS direct services, namely, Specialized Treatment and Treatment Support. Specialized Treatment and Treatment Support are provided to a child by a home-based worker (paraprofessional) in accordance with the approved Treatment Plan and under the supervision of the licensed clinical supervisor.

1) **HBTS Specialized Treatment:** One-on-one therapeutic services given to a child by a home-based worker (paraprofessional) in accordance with the approved Treatment Plan and under the supervision of the licensed clinical supervisor. Treatment may address the development of behavioral, communication, social, and functional skills, as well as reinforce skills included in a child's Individual Educational Plan (IEP) or Individualized Family Service Plan (IFSP). For some children, it may be appropriate

[1] Department of Health licensed health care professionals eligible to serve in this capacity for HBTS include the following categories: psychologist, licensed independent clinical social worker, marriage and family therapist, mental health counselor, occupational therapist, physical therapist, speech and language pathologist and/or registered nurse with a Masters degree.

[2] Licensed health care professionals eligible to provide Clinical Supervision include the following categories: licensed independent clinical social worker, marriage and family therapist, mental health counselor, registered nurse with a Masters degree, psychologist and/or psychiatrist.

to integrate the recommendations of a licensed Occupational Therapist (OT), Physical Therapist (PT), and Speech Pathologist (SLP) into an HBTS Treatment Plan in order to provide additional practice on targeted skills. This can only occur for children receiving these therapies as part of an IEP or IFSP. Such activities are intended to help with mastery but are not a substitution for actual therapy provided by an OT, PT or SLP therapist. Refer to Section 5.4.2 for greater detail regarding this service.

2) **HBTS Treatment Support:** This enhanced service allows for a portion of approved HBTS hours to be used for the purposes of providing structure, supervision, guidance, and redirection when the child is not directly engaged in active goal-directed treatment. The latter often involves intensive periods of practice or application of reinforcement procedures in efforts to improve skill levels and/or change inappropriate behaviors. DHS recognizes that for some children and adolescents with moderate to severe mental retardation, other developmental disorders, and neuro-medical conditions the ability to fully participate in goal-directed HBTS is severely limited by their level of functioning and coexisting condition(s). The frequency and intensity of engaging in sustained Specialized Treatment can become too taxing and may be of limited effectiveness. The intent of Treatment Support is to facilitate the child's ability to remain at home, maintain activities of daily living, and transition to adulthood. The Clinical Supervisor must direct the activities of the home-based worker providing Treatment Support. Section 5.4.2.2 provides more detailed information regarding this service.

1.1.1.3 Child Specific Orientation for Newly Assigned Home-Based Worker

The purpose is to provide the newly assigned home-based worker with detailed knowledge about a child's condition, treatment goals and objectives, methods of intervention, and other related aspects of care such as observing the child and/or other staff working with the child. It is provided by the Treatment Consultant, Clinical Supervisor, and with an experienced home-based worker when necessary, to prepare staff to work with a child and family already receiving HBTS (See: Section 5.4.3).

1.1.1.4 Social Skills Group Therapy

Social skills group therapy can be included and paid for as an additional component of treatment when provided by a licensed health care professional.[3] Social skills development is of maximum benefit when children are able to carryover skills into naturally occurring community settings. It is critical that children involved in social skill groups also receive coaching and the support of HBTS staff to use and practice new skills. Learning is enhanced when children learn social skills in real life settings from and with typically developing age peers.

[3] Licensed health care professionals eligible to provide Social Skills Group Therapy include: licensed independent clinical social worker, marriage and family therapist, mental health counselor, and psychologist.

1.1.1.5 Treatment Consultation

Treatment consultation is intended to bring specific expertise and direction to the therapeutic regimen employed in the Treatment Plan. Treatment consultation may focus on Treatment Plan implementation, response of the child to the therapy, approaches to understanding and addressing emerging issues in the course of treatment, and adjustment to treatment mode. Treatment consultation shall be provided to the treatment team (Clinical Supervisor, home-based worker) by a licensed health care professional[4] with recognized expertise in the specific area of the child's needs.

1.1.1.6 Treatment Coordination

Treatment coordination represents activities by a team member on behalf of a specific child receiving HBTS services to ensure coordination and collaboration with parents, providers, the medical home, and other agencies (e.g., school, Early Intervention, DCYF or CASSP) including the CEDARR Family Center. Collaboration and communication is ongoing throughout a child's course of HBTS.

1.2 Intended Outcomes of Certification Standards and Services

The development of Certification Standards and the provision of certified Home Based Therapeutic Services are intended to:

1) Demonstrably improve the functioning of children with special health care needs as set forth in approved Treatment Plans; and/or facilitate their ability to live at home and actively participate as valued members of their families and communities to the best of their abilities and to support the transition to adulthood.

2) Improve the access to provision of services as authorized by DHS or CEDARR Family Centers. Certified HBTS direct service providers are expected to render efficient, cost-effective treatment aimed at addressing clearly defined treatment goals and objectives

3) Improve monitoring, oversight and quality assurance of HBTS provider-agencies by DHS. Regular performance reports will be provided to DHS.

4) Improve program reliability, consistency, and quality of service across provider-agencies by adhering to policies and DHS requirements governing the operation of HBTS. Existing HBTS provider-agencies must fully meet these Certification Standards by April 1, 2003. All new provider-agencies are to fully meet Certification Standards in order to provide HBTS.

[4] Licensed health care professionals eligible to provide Treatment Consultation include: psychiatrist, psychologist,
licensed independent clinical social worker, marriage and family therapist, mental health counselor, occupational therapist, physical therapist, speech and language pathologist, and registered nurse with a Masters degree.

5) Increase provider capacity by adding new provider-agencies.

6) Assure the adherence to family centered principles in the service relationship between provider-agency and family.

1.3 HBTS as a CEDARR Direct Service

Certification of provider-agencies for the provision of Home Based Therapeutic Services is intended to further the "Statewide Vision for Children and Families with Special Health Care Needs." This vision was developed by the Leadership Roundtable on Children with Special Health Care Needs, a representative group of family members, providers, public and private administrators and advocates convened for planning purposes by the Director, Department of Human Services.

Statewide Vision "All Rhode Island children and their families have an evolving, family centered, strength based system of care, dedicated to excellence, so they can reach their full potential and thrive in their own communities." Leadership Roundtable on Children and Their Families with Special Health Care Needs, April 15, 1999

CEDARR stands for **C**omprehensive **E**valuation, **D**iagnosis, **A**ssessment, **R**eferral and **R**eevaluation services and supports. The CEDARR Program Initiative includes two broad delivery system components:

- CEDARR Family Centers, and
- CEDARR Certified Direct Services

The CEDARR Family Center Certification Standards more fully describe the role of the CEDARR Family Centers and the related Certification Standards. They are available on line on the DHS website reached at www.dhs.state.ri.us

CEDARR Direct Services are specific services developed pursuant to the CEDARR Initiative and available to Medicaid beneficiaries when included as part of an approved CEDARR Family Center Family Care Plan. Development of CEDARR Direct Services is based on two principles:

1) Identify current service needs and gaps in health care services for children and families with special health care needs; and

2) Establish and operate an accountable system for the purchase of appropriate, high quality services to meet those needs.

These CEDARR Direct Service Certification Standards for HBTS specify the requirements that must be met to be a certified provider and provide guidance to interested parties who may choose to apply for certification. DHS reserves the right to amend these standards periodically, with reasonable notice to participants.

1.3.1 Prior Authorization, Coordination with CEDARR Family Center or DHS, and Reimbursement

HBTS requires prior authorization from DHS or a CEDARR Family Center in order to be reimbursed for services. HBTS provider-agencies are notified in writing by Electronic Data Systems (EDS)[5] that an authorization has been formally entered into the claims system. Services provided in the absence of a prior authorization shall not be reimbursed.

1.3.2 Period of Authorized Service and Reimbursement

The period of authorized service is stipulated in the prior authorization (PA) notice. The PA stipulates the number of approved units of component services by type. Reimbursement will be based on units of service provided as part of an authorized Treatment Plan (e.g., home-based treatment hours, treatment consultation, clinical supervision, treatment coordination, etc.).

The maximum period for authorization of a HBTS Treatment Plan is six months. There is no limit to the number of HBTS treatment cycles that can be authorized by DHS or a CEDARR Family Center. A child can receive HBTS from only one agency during a given authorization period.

1.3.3 HBTS Authorization Process (CEDARR and DHS)

Currently there are two paths to obtaining HBTS. One is through a Treatment Plan approved by a CEDARR Family Center and the other is through a Treatment Plan approved directly by DHS.

Effective January 1, 2003, the CEDARR Family Centers will initiate all new HBTS requests to provider-agencies, provide clinical reviews for these referrals, and render authorizations for said Treatment Plans. DHS intends that at some future date, all HBTS will result from a CEDARR referral and authorization process. Provider-agencies, families and the public will be informed of this decision once a date has been determined. Additional information regarding the management of existing wait lists held by provider-agencies is described in Section 5.10.

1.3.4 Coordination with CEDARR Family Center for Prior Authorization of HBTS

A family may contact a CEDARR Family Center for a variety of reasons, including recommendation by an HBTS provider-agency. Based on the child and family's interest, the CEDARR Family Center will conduct an Initial Family Assessment (IFA), working with the family to understand their special needs and circumstances, and review available options. As appropriate, the CEDARR Family Center develops a Family Care Plan (FCP) that may identify a

[5] EDS is the fiscal agent for DHS. All claims are adjudicated by EDS in accord with DHS and Federal Medicaid policy and program rules.

range of specialized service options and providers, including recommendations for CEDARR Direct Services (e.g., HBTS).

If HBTS is identified as a direct service, the CEDARR Family Center will inform the family of available choices of certified provider-agencies for HBTS. The family, with guidance from the CEDARR Family Center, if desired, will choose the provider-agency from which they want to receive services. The CEDARR Family Center will provide information from its own assessment to the HBTS provider-agency to avoid duplication of effort and unnecessary repetitions by the family. This also minimizes the work otherwise required of the HBTS provider-agency to develop a proposed Treatment Plan.

In developing the proposed Treatment Plan, the HBTS provider-agency will conduct a more focused assessment directed toward determining the specifics of the proposed treatment plan. The CEDARR Family Center will review the proposed Treatment Plan and based on the clinical review and concurrence, the prior authorization is made.

Appendix 2 provides a further outline of the CEDARR authorization process.

1.3.5 Coordination with DHS for Prior Authorization of HBTS

Until January 1, 2003 families may choose to directly obtain HBTS through authorization by DHS. DHS does not, however, initiate referrals, assess for clinical appropriateness, or arrange for HBTS treatment. DHS does assist families by providing them with updated lists of available HBTS resources.

After a detailed interview process, the HBTS provider-agency in conjunction with the family prepares a proposed Treatment Plan that defines treatment goals and objectives, treatment intensity, hours of scheduled service, approach in working with the family, and other relevant considerations. The proposed Treatment Plan is then submitted to DHS for clinical review and authorization. On the basis of this review and final action, a prior authorization is entered into the EDS system.

For the reauthorization of HBTS services for children who have had no contact with a CEDARR Family Center, DHS will continue to provide clinical review and approval for treatment for services until otherwise notified. Appendix 3 provides an outline of the DHS authorization process.

1.4 Commitment to Family Centered Care

The CEDARR Initiative seeks to incorporate the key elements of family centered, community-based care into practice. Participating providers of HBTS are required to develop practices and services consistent with the principles of family centered care. Core practices of family centered care include:

1) Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service system and support personnel within those systems fluctuate.

2) Providing individualized services in accordance with the unique needs and potential of each child and guided by the child and family specific care plan that recognizes health, emotional, social, and educational strengths, as well as needs.

3) Facilitating family/professional collaboration at all levels of hospital, home and community care.

4) Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.

5) Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational and geographic diversity.

6) Encouraging and facilitating family-to-family support and networking.

7) Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

8) Ensuring services that enable smooth transitions among service systems and natural supports, which are appropriate to developmental stages of the child and family.

9) Full disclosure to families of any anticipated delays in start of services, changes in personnel, and provider-agency policies and procedures in the provision of home-based services.

2.0 CERTIFICATION PROCESS

2.1 Submission of Certification Application Required

There is no limit to the number of entities that may become certified as provider-agencies of HBTS. Applications for certification may be submitted by agencies providing HBTS services prior to the issuance of these standards or by any other entity seeking to become a provider of HBTS. All HBTS applicants will be evaluated on the basis of written materials submitted to DHS addressing Certification Standards. DHS reserves the right to conduct on-site reviews and to seek additional clarifications prior to final scoring.

Potential applicants may submit applications for certification to DHS any time after the issuance of these Certification Standards Application reviews will be scheduled periodically by DHS based on receipt of applications. Provider-agencies will be notified of their certification status when the review is complete. Applicants should anticipate a minimum of two months for the review process.

During the initial period of application review and certification subsequent to the issuance of these standards DHS sets forth the following schedule. HBTS provider-agency certification applications must be received by DHS by October 15, 2002 in order for the provider-agency to become certified by January 1, 2003. In order for an applicant to be assured of sufficient time for review and certification by April 1, 2003[6] the application must be received by DHS by January 15, 2003. Provider-agencies submitting applications by October 15, 2002 will be informed regarding certification status no later than December 16; provider-agencies submitting applications by January 15, 2003 will be informed regarding certification status no later than March 15, 2003.

2.2 Instructions and Notifications to Applicants

This document sets forth the Certification Standards for direct service providers of HBTS. In accepting certification from DHS, Certified CEDARR direct service providers agree to comply with these certification standards as presently issued and as amended from tine to time by DHS, with reasonable notice to providers.

These Certification Standards also provide the application guide for applicants. Sections 6 and 7 of this document identify the core standards against which applicants will be evaluated.

Within Sections 6 and 7, specific standards and expectations are identified. Applications will be scored on the basis of responses to each of these specific standards and expectations. Applications are to address each of these areas in the sequence presented. Applicant are to use

[6] April 1, 2003 is the date by which HBTS providers must be certified in order to be eligible for reimbursement by DHS for HBTS services provided subsequent to March 31, 2003. Note that specific exceptions to this requirement may apply; for example, in order to facilitate orderly transitions in services for children, agencies which are discontinuing their participation as an HBTS provider may be eligible for continued reimbursement for services provided through September 30, 2003 to children with a DHS approved Child Specific Transition Plan..

the numbering system in these standards to identify the sections being addressed in the application.

An Application Guide is presented in Attachment A to guide the organization of application materials. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these Certification Standards will be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

Interested parties are encouraged to contact the Center for Child and Family Health (CCFH) for further information and clarification. Letters of Interest are strongly encouraged to ensure that DHS is able to keep interested parties up to date regarding scheduled meetings or program clarifications that may be needed. Inquiries and completed applications should be directed to:

Anne M. Roach, RN, MEd
Consultant Public Health Nurse
Center for Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920
Phone: (401) 462-6370

Once a provider is certified as eligible to provide HBTS, the provider shall be enrolled with EDS as a provider of these services. If you have any questions about the enrollment form or enrollment process, please call EDS at 1-800-964-6211.

2.3 Information for Interested Parties

Upon initial release of these CEDARR HBTS Direct Service Provider Certification Standards, DHS staff will be available to provide information for those pursuing certification applications. If appropriate, DHS will provide written addenda to these standards to further clarify certification requirements.

2.4 Certification

As set forth in these standards, certification as a HBTS provider is required in order for DHS to reimburse a provider agency for provision of HBTS services. Certification requires that provider-agencies adhere to these standards and performance expectations, as well as provide periodic reports to DHS. These Certification Standards include certain performance standards.

Subsequent to certification DHS will monitor the performance of certified HBTS provider agencies and their continued compliance with certification requirements. Certified agencies are required to notify DHS of any material changes in their organization's circumstances or in

program operations. On the basis of ongoing monitoring, including review of required reports submitted by certified provider-agencies, DHS may identify deficiencies in performance and/or compliance with certification requirements. Based on such review and related communications, certification status may be modified to Provisional Certification. Fully certified and Provisionally Certified agencies will be reimbursed using different rate schedules (see Table 2 in Section 2.4.2 for Rate Schedules; see Section 2.5, "Continued Compliance with Certification Standards" for a fuller discussion of Provisional Certification).

2.4.1 Possible Outcomes of Certification Review Process

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a program that complies with the requirements set forth in these HBTS Certification Standards.

Three basic outcomes are possible as a result of the application review process. These are:

- Certification with no conditions
- Certification with conditions
- Not certified

As a result of the review, provider-agencies may be deemed in compliance with all requirements and be offered "Certification with no conditions". Alternatively, an applicant may describe a program that meets most of the Certification Standards, but for one reason or another does not fully comply with the certification requirements at the time of application submission. In such case the applicant may be offered "Certification with conditions" and application deficiencies will be identified by the State. The applicant will be required to address them by submitting a corrective action plan with specific dates for addressing deficient areas of compliance. This plan must be accepted and approved by DHS.

In other cases the review team may determine that an application does not meet the requirements for certification and certification will not be offered to that agency. Deficiencies in the application will be identified. This will be done without prejudice and interested applicants will be encouraged to address deficiencies and submit an amended application. Certification is not a competitive process limited to a fixed number of providers. Rather, all applicants which demonstrate preparedness to comply with the standards will be certified.

Special circumstances may occur wherein an existing agency does not submit a certification application or an existing agency does not submit an application which would result in certification. These are reviewed in Section 2.6 "Special Circumstances".

2.4.1.1 Certification Offer

DHS will convene an application review committee to evaluate applications and submit recommendations on certification to the Associate Director, Division of Health Care Quality, Financing and Purchasing, Department of Human Services. Based on a positive action a letter

will be sent to the application agency offering certification to the agency and identifying any conditions to the certification. A signed acceptance of certification is required.

2.4.1.2 Period of Certification

The first period of certification will begin no earlier than January 1, 2003. Certification will be granted for up to a three-year period. Extension of certification beyond the three-year period will be granted based on a new certification application for an additional period. DHS also reserves the right to extend certification beyond the three-years without application for one or more certified provider-agencies.

2.4.2 Certification Status and Reimbursement Schedules

Reimbursement for services varies based on certification status. Table 1 lists the possible outcomes of the certification review process and related reimbursement rate schedule.

Table 1: Certification Status and Applicable Reimbursement Schedule

Certification Status	Reimbursement Rate Schedule effective January 15, 2003	Reimbursement Rate Schedule effective April 1, 2003
Certified – with no conditions	Schedule A	Schedule A
Certification – with conditions	Schedule A	Schedule A
Existing provider agency, not certified	Schedule B	Not applicable
Provisional Certification *(applies only where a certified agency is deemed to be out of compliance with standards; provisional certification status cannot last longer than six months; see Section 2.5)*	Schedule B	Schedule B

Table 2 lists each of the HBTS services and the related schedules of reimbursement. These rates are effective for services provided beginning January 15, 2003.

Table 2 lists each of the HBTS services and the related schedules of reimbursement. These rates are effective for services provided beginning January 15, 2003.

Table 2: Service Description and Schedules of Reimbursement

Service Description	Rate Schedule A (1 unit = 30 minutes)	Rate Schedule B (1 unit = 30 minutes)
Treatment Consultation - Doctoral Level Staff	$35.00	$30.00
Treatment Consultation - Masters Level Staff	$30.00	$25.00
Treatment Consultation: OT, PT, & SP	$30.00	$25.00
Clinical Supervision of Home-Based Worker - Doctoral Level Staff	$35.00	$30.00
Clinical Supervision of Home-Based Worker - Masters Level Staff	$30.00	$25.00
Clinical Supervision of Home-Based Worker - Bachelors Level Staff	$16.50	$14.00
Clinical Supervision of Treatment Support Worker – Doctoral Level Staff	$35.00	$30.00
Clinical Supervision of Treatment Support Worker - Masters Level Staff	$30.00	$25.00
Clinical Supervision of Treatment Support Worker – Bachelors Level Staff	$16.50	$14.00
Home Based Therapy – Specialized Treatment	$13.23	$11.50
Home Based Therapy – Treatment Support	$10.50	$9.50
Child Specific Orientation – Newly Assigned Worker	$80.00 for each orientation	$80.00 for each orientation
Treatment Coordination	$16.50	$16.50
Social Skills Group	$11.00	$11.00

2.5 Continued Compliance with Certification Standards

Certified HBTS providers shall comply with these HBTS Certification Standards throughout the period of certification. Failure of DHS to insist on strict compliance with all certification standards and performance standards shall not constitute a waiver of any of the provisions of

these certification standards and shall not limit DHS' right to insist on such compliance. DHS reserves the right to monitor and evaluate provider-agencies of HBTS for compliance with Medicaid and State laws, as well as these Standards and DHS regulations and policies pursuant to the management of HBTS. HBTS providers are required to provide periodic reports to DHS as identified in Section 6.6, "Service Monitoring and Reporting". For purposes of review, certified and provisionally certified providers will provide access to DHS and/or its agents at reasonable times to appropriate personnel and written records.

DHS reserves the right to apply a range of sanctions to providers which are out of compliance. These may include:

a) Suspending new referrals.
b) Change of certification status to Provisional Certification.
c) Recoupment of funds when violations of Medicaid regulations, State law, or DHS policies, including these Certification Standards have taken place.
d) Dependent on severity of violation, suspension of certification
e) Referral to appropriate legal authorities.

2.5.1 Provisional Certification

As a result of its review activities DHS may identify deficiencies wherein an agency is not in satisfactory compliance with the certification and or performance standards. In such instance, DHS will notify the agency in writing of such deficiencies and will set forth a period of time within which the agency must come into compliance or provide a corrective action plan acceptable to DHS. Such corrective action plan will include specific steps to be taken to come into compliance and defined dates for achievement of those steps.

Provisional Certification shall commence on the one hundred twenty-first (121st) day following formal notice by DHS to the provider identifying elements of non-compliance with the certification or performance standards if the provider has not a) cured the identified deficiencies, or b) submitted an appeal to DHS disputing the non-compliance, and setting forth the factual basis on which the notice of non-compliance is disputed, and having its appeal sustained by DHS Such an appeal must be submitted no later than thirty (30) days following DHS' notice of non-compliance.

In the event that a provider's agency-level appeal is not successful, the provider may pursue an APA appeal to Superior Court. In the event a provider takes this action, imposition of Provisional Certification will be stayed pending the outcome of the appeal.

In the event that the defined non-compliance is child-specific, and DHS is reasonably convinced that continued non-compliance by the provider will result in harm to a child or will jeopardize the safety of a child, DHS may order an immediate cessation of services. Failure to respond to such an order shall result in immediate termination of services for that child.

2.6 Transition Plans for Children Served by Agencies Not Seeking or Not Achieving Certification – Special Designation

In order for agencies to receive reimbursement for services rendered after March 31, 2003, the agency must be certified. There are two reasons that an existing provider would not be certified as of that date.

- The agency has chosen not to apply for certification
- The agency has applied for certification but the agency has not been certified.

In these cases, the time period for reimbursement by DHS may be extended through Special Designation for services provided through September 30, 2003. The purpose of this Special Designation would be to support continuity of treatment for affected children and to effect an orderly transition.

Special Designation will enable an agency to be reimbursed for authorized services for specified children for services provided between April 1 and September 30, 2003. This will apply to services for children for whom a Child Specific Transition Plan has been provided to, and approved by, DHS.

Note that because certification applications must be submitted by January 15, 2003 in order to be assured of action by April 1, no new treatment plans will be approved after January 15, 2003 for agencies which have not submitted an application for certification by that date.

Any agency which makes a decision not to apply for certification prior to that date is requested to notify DHS at the earliest point possible so that transition plans can be arranged.

In the event that an agency does make timely application for certification but that application is not approved, Child Specific Transition Plans are to be submitted within thirty (30) days following notification by DHS. DHS will work to promote continuity of care for children and will work collaboratively with agencies if circumstances exist which could allow the agency to promptly address certification deficiencies.

2.7 Licensure Requirements for Service Providers in Certified HBTS Provider Agencies

A requirement for certification is that all clinical staff engaging in providing clinical supervision or treatment consultation must be health care professionals licensed by the Department of Health (DOH) of Rhode Island. In addition, licensed clinical staff must be able to demonstrate clinical competency[7] to render treatment consultation or clinical supervision to home-based staff. Note that a list of clinical staff, their discipline and license number must be included in the application for certification.

[7] Competencies are established by formal education, continued education credits, internships, work history, and supervised practice. Refer to Appendix 4 for additional information.

The foregoing provisions notwithstanding, non-licensed individuals employed by existing HBTS provider agencies and identified as clinical staff as otherwise described herein may continue in those roles under special conditions, as described below and in Appendix 4.

2.7.1 Special Conditions for Non-licensed Clinical Staff at Existing HBTS Provider Agencies

In some cases the licensure requirement could cause hardship for children and families and for personnel who have been performing these clinical roles at HBTS provider agencies. On a case-by-case basis, DHS may allow unlicensed clinical personnel, when permissible by Medicaid regulations and State law, to provide HBTS Clinical Supervision services.

Conditions which may permit unlicensed personnel to provide clinical supervision, are explained below and in detail in Appendix 4.

To be eligible for exception individuals must be currently employed by an existing HBTS provider in a clinical supervision capacity as of August 15, 2002, have a minimum of a bachelor's degree in a related field[8] and meet all other requirements listed in Appendix 4. This exception remains in effect only as long as the individual is employed by that particular provider-agency. It cannot be transferred or shared if the individual is working at more than one agency.

Individuals seeking this exception must be specifically identified in the certification application submitted by the agency and approved in writing by the state. The provider-agency must identify the steps to be taken to ensure that all clinical supervisors become licensed health care professionals with established competencies to address the needs of the HBTS target population. There is no limit on the number of possible candidates per provider-agency. Exception status must be renewed during each of the three years, based on continued employment with the agency and completion of required continued education hours (see Section 6.4.2.3).

2.7.2. Clinical Oversight and Monitoring of Non-licensed Clinical Supervisors

As of January 1, 2003, DHS requires that for each recipient of HBTS, a licensed and competent health care professional oversee all non-licensed staff providing clinical supervision and treatment consultation. This clinician assumes all responsibility for clinical services provided to a child and family. In order to ensure that the clinical supervisor is providing appropriate guidance and direction to the home-based workers, the licensed health care professional must:

1) Be knowledgeable of the Treatment Plan's goals and objectives

2) Be knowledgeable of methods of intervention and child's progress

3) Observe a supervision/consultation session twice within an authorization period with clear entry in the clinical record describing observation and consultation

[8] Minimum of a Bachelor's degree in special education, child development, psychology, counseling, social work or nursing.

4) Review written documentation of supervisory/consultation sessions on a monthly basis

5) Meet with the non-licensed staff that is providing clinical supervision or treatment consultation to address treatment concerns (frequency determined by the licensed health care professional)

6) Sign all Treatment Plans

DHS has the sole discretion to invoke any and all remedies upon identification of performance deficiencies as well as unethical or illegal conduct. Refer to Appendix 4 for further information regarding licensure and practice standard.

2.8 Status of Current Home-Based Workers

Home-based workers hired after January 1, 2003 are required to meet Certification Standards regarding staffing qualifications **(**See Section 6.4.2.3.).

Home-based workers currently employed by provider-agencies who do not meet these certification qualifications will be allowed to continue in their current positions. This exception remains in effect only as long as the individual is employed by the agency in that position. It cannot be transferred to another agency or shared if the individual is working at more than one agency.

2.9 DHS Responsibilities

DHS has the responsibility to inform appropriate State agencies of any instances of fraud, suspected fraud or misuse of Medicaid funds and professional misconduct.

As a Medicaid provider, the provider-agency is obligated to comply with all applicable state and federal rules and regulations. Certified provider-agencies agree to comply with DHS program requirements. DHS reserves the right to amend program requirements from time to time, with reasonable notice to participating provider-agencies.

2.9.1 Oversight and Authorization

DHS or the CEDARR Family Center, in accordance with Medicaid regulations may, place limits on services (e.g., establish amount, duration, and scope of services) and exclude any item or service that it determines is not medically necessary, is unsafe, experimental, or is not generally recognized as an accepted method of medical practice or treatment.

3.0 BACKGROUND TO DEVELOPMENT OF HOME BASED THERAPEUTIC SERVICES

3.1 History

Since the mid-1990's, intensive HBTS have been provided to certain children under the provisions of Early Periodic Screening, Diagnosis and Treatment (EPSDT). HBTS represents an array of therapeutic services designed to reduce or ameliorate deficits in cognitive, communication, psychosocial, and physical functioning in children with special health care needs and is expected to maintain, stabilize and/or improve adaptive functioning. HBTS provides intensive treatment through the application of professional and research based interventions.[9]

DHS has consistently stated that "best practices" are required of HBTS providers. The November 1999 Guidelines stated that:

1) Provider-agencies of HBTS shall adhere to evidence – based treatment approaches.

2) Treatment interventions that are lacking ~~in~~ scientific research and support will not be approved.

3) Interventions that are of an "experimental" nature may be considered but the provider-agency will need to present scientific information to support proposed clinical interventions.

HBTS are intended for a child living at home (or foster home) and participating in the community. HBTS vary with respect to scope of treatment services, treatment objectives, intensity of treatment hours provided, and duration of care. These factors are modified~~,~~ as a child's needs change.

Since its inception, utilization of this service has increased substantially, involving a range of provider-agencies. Over this time, DHS has implemented various requirements to provide additional structure, quality assurance and accountability for services. These Certification Standards serve to both continue this process and to assemble all program requirements within a single document.

[9] Refers to evidenced-based treatment and consensus-based treatment protocols cited in professionally respected journals. While research articles are not be immune to errors, built-in checks and balances include emphasis on objective data, independent replication, and critical peer review of research reports. Experimental or unsubstantiated treatments are not acceptable.

4.0 TARGET POPULATION AND LOCATION OF SERVICE WITHIN CONTINUUM OF CARE

4.1 Eligibility

The population eligible to be served by Home Based Therapeutic Services is:

1) Medicaid eligible children, from birth to their twenty-first birthday. This includes children who are eligible for Medical Assistance through Supplemental Security Income (SSI), Katie Beckett (through age 18), adoption assistance, RIte Care, and RIte Share. These children have potentially chronic (twelve months or longer in experienced or expected duration) and moderate to severe cognitive, developmental, medical and/or psychiatric conditions whose level of functioning is significantly compromised.

4.2 Home Based Therapeutic Services Within the Continuum of Care; Appropriateness of this Level of Care

HBTS is an intensive outpatient service option within the continuum of care. It is not as restrictive as a day treatment program, inpatient hospitalization or residential level of care; it is more intensive and of greater frequency than typical outpatient services. HBTS services may be provided in conjunction with other outpatient services as part of a coordinated program of care.

As a point of reference, Appendix 5 includes a description of conditions typically associated with the target population and HBTS. Decisions regarding the appropriateness of this intervention need to take into consideration the appropriateness criteria for HBTS set forth below.

4.2.1 Clinical Appropriateness Criteria for Initiation of Service

These criteria pertain to the initial determination of appropriateness. Treatment Plan approval requires all of the following criteria to be met and documented:

1) A formal diagnosis made within the last two years is required by an appropriately licensed health care professional with competence in child psychology, child psychiatry, or child development.

2) The individual demonstrates symptomatology consistent with a DSM-IV or ICD-9 diagnosis that requires, and on the basis of best available clinical and evidence based practice standards can be expected to respond to, HBTS intervention.

3) The individual presents with medical and/or physical condition(s) that require intensive therapeutic intervention.

4) Outpatient services provided at an intensified level have not been sufficient.

5) There is evidence that a comprehensive integrated program of medical and psychosocial services is needed to support improved functioning at the least restrictive level of care.

6) The individual and family require support in order to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting.

7) The individual, the parents, or the individual's legal guardian, if appropriate, are willing to accept and cooperate with HBTS, including the degree of parental participation outlined in the HBTS Treatment Plan.

In some instances, the following criteria may also apply:

8) The individual may be at risk for hospitalization(s) or out-of-home placement.

4.2.2 Clinical Appropriateness Criteria for Continuing Care

Reasons for a Treatment Plan at this level of care to be continued and/or reauthorized involve all of the following criteria:

1) Severity of condition(s) and resulting impairment continue to require this level of treatment.

2) Treatment Planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The mode, intensity and frequency of treatment are appropriate and consistent with best known clinical and/or evidence based practice.

3) Active treatment is occurring and continued progress toward goals is expected. Progress in relation to goals is clearly evident, measurable and described in observable terms.

4) Treatment objectives have not yet been achieved; documentation supports continued interventions.

5) The family is participating to the extent that it is medically and psychosocially capable or able.

4.2.3 Discontinuing Services

Reasons for a Treatment Plan to be terminated can involve any of the following criteria:

1) Loss of Medicaid eligibility (See Appendix 6: Provider-Agency Responsibility for Monitoring of Medicaid Eligibility).

2) Issues that may necessitate termination or temporary suspension of care during a period of authorized treatment include:

   a) The individual is at risk of harm to self or others, or sufficient impairment exists requiring a more intensive level of service beyond community-based intervention.

b) The individual's home environment presents safety risks to the staff making home visits. These include, but are not limited to: sexual harassment, threats of violence or assault, alcohol or illegal drug use, and health risks.

c) The individual, family, or guardian is not successfully following the provider-agency's program rules and regulations, despite multiple, documented attempts to address non-compliance issues.

d) The provider-agency is unable to maintain staffing for an authorized Treatment Plan and, therefore, treatment goals cannot be adequately addressed during a period of care.

All instances and circumstances that effect temporary suspension of services or termination are serious. Provider-agencies have the obligation to effect a smooth transition, whenever possible, and are required to conform to the rules and requirements stipulated by DHS. [10]

4.2.4 Discharge Criteria

Reasons to end HBTS can include any of the following criteria to end this level of care:

1) Individual's documented Treatment Plan goals and objectives have been successfully met.

2) Individual no longer meets service initiation or continuing care criteria, or meets criteria for a less/more intensive level of care.

3) Withdrawal of consent from the recipient at age 18, and/or his/her parents or legal guardian withdraw treatment consent.

4) Loss of Medicaid eligibility (See Appendix 6: Provider Responsibility for Monitoring of Medicaid Eligibility).

4.3 Potential of Service and Limitations of Service

4.3.1 Potential of Service

HBTS is unique because services are delivered in a child's home and other age-appropriate community settings with direct and ongoing parent participation to maximize therapeutic effectiveness. As children learn to apply these skills within the family and age-appropriate community settings, HBTS enhances their abilities to actively participate as valued family and community members. This allows for treatment consistency across settings and improvement in communication, behavior, psychosocial skills, and developmental functioning of a child receiving HBTS.

[10] Provider-agency responsibility to discontinue treatment in a responsible manner is of paramount importance to DHS and families. Appendix 10 addresses situations and required processes for discontinuation or temporary suspension of HBTS.

Through a strong relationship between the CEDARR Direct Service Provider-agency and the CEDARR Family Center, a strong and mutually reinforcing integration of services for the child and family can be achieved.

4.3.2 Limitations of Service

DHS or the CEDARR Family Center reserve the right to determine that HBTS are being used appropriately to reach target populations. The degree of appropriateness will depend on the target population served and the individual needs of the child. The following guidelines shall be followed:

1) HBTS will not be used for respite or childcare.

2) It is expected that a course of outpatient treatment by a licensed mental health professional has been attempted prior to seeking HBTS. (See Section 4.2.1).

3) For children with psychiatric/behavioral conditions, a previous evaluation by an appropriately licensed mental health professional must have taken place within two years prior to the start of an initial HBTS Treatment Plan. During the course of HBTS care, an additional evaluation must take place within two years following the beginning of home-based treatment as needed.

4) HBTS will not exist in isolation when other supports are indicated (e.g., family or individual psychotherapy, medical treatment, or school services and Early Intervention). HBTS are expected, when appropriate, to complement other services already in place for the individual. HBTS is not a substitute for mental health services provided by licensed professional clinicians.

5) When children do not meet admission criteria for HBTS, other services should be investigated.

6) HBTS will not take the place of services provided by Private Duty Nursing, Pediatric Home Care or the roles and responsibilities assigned to Certified Nursing Assistants (e.g., personal care, basic nursing skills, rehabilitation skills, care of patient environment, and recognition/reporting of symptoms). However, it is recognized that some children may require both HBTS and nursing care, including CNA services.

7) Experimental treatments are not reimbursed.

5.0 SERVICE DESCRIPTION - REQUIRED SCOPE OF SERVICES

5.1 Service Name and Definition

Home Based Therapeutic Services are specialized health services delivered in a child's home and in community settings. HBTS represents an integrated set of service components involving the provision of Specialized Treatment provided in accord with an approved individualized Treatment Plan with measurable goals and objectives. All Treatment Plans must be approved by a designated licensed health care professional within the HBTS agency. Once approved by a CEDARR Family Center or DHS, the HBTS staff implements the Treatment Plan.

5.2 Service Components

An integrated HBTS Treatment Plan can include, in specified amounts as set forth in an approved HBTS Treatment Plan, the following reimbursable service components:

- Treatment Consultation
- Clinical Supervision
- Treatment Coordination
- Home Based Therapy Direct Services
  - HBTS Specialized Treatment
  - HBTS Treatment Support
- Social Skills Group Therapy
- Child Specific Orientation for Newly Assigned Home-Based Worker

5.3 Units and Rate of HBTS Services

Rates of reimbursement are based on the certification status of the provider-agency. The provider–agency may be fully certified or provisionally certified based on compliance with Certification Standards, including reporting requirements and levels of performance as stipulated in these standards. Refer to Table 3 for the authorized rates for each service.

Unless otherwise specified by DHS, provider-agencies will be reimbursed only for the unit of service actually delivered each month at allowable rates. A unit is **one half hour of service** (30 minutes).

Table 3: Home-Based Therapeutic Service Units

HBTS provider-agencies are to comply with all established DHS billing reimbursement practices, and all future modifications as directed.

Table 3: New Rate for Scheduled HBTS

Description	Rate Schedule A (1 unit = 30 minutes)	Rate Schedule B (1 unit = 30 minutes)
Treatment Consultation - Doctoral Level Staff	$35.00	$30.00
Treatment Consultation - Masters Level Staff	$30.00	$25.00
Treatment Consultation: OT, PT, & SP	$30.00	$25.00
Clinical Supervision of Home-Based Worker Doctoral Level Staff	$35.00	$30.00
Clinical Supervision of Home-Based Worker Masters Level Staff	$30.00	$25.00
Clinical Supervision of Home-Based Worker Bachelors Level Staff	$16.50	$14.00
Clinical Supervision of Treatment Support Worker - Doctoral Level Staff	$35.00	$30.00
Clinical Supervision of Treatment Support Worker - Masters Level Staff	$30.00	$25.00
Clinical Supervision of Treatment Support Worker - Bachelors Level Staff	$16.50	$14.00
Home Based Therapy - Specialized Treatment	$13.23	$11.50
Home Based Therapy - Treatment Support	$10.50	$9.50
Child Specific Orientation - Newly Assigned Worker	$80.00 for each orientation session	$80.00 for each orientation session
Treatment Coordination	$16.50	$16.50
Social Skills Group	$11.00	$11.00

5.4 Description of Service Components

Table 4 provides a description of service components, required personnel qualifications, rates, range of approved hours, and functions assigned to each service component. Further elaboration is contained in sections 5.4.1 – 5.4.6.

Table 4: HBTS Reimbursable Services

HBTS Service Name	Personnel	Qualifications	Approved Units per plan (1 unit=30 minutes)	Comments
Treatment Consultation	Treatment Consultant	• Licensed health-care professional with established competencies in working with children with special health care needs * • Masters or Doctoral degree	Minimum None Maximum 2 units per week	• Not the same person as clinical supervisor. • Provides specific expertise and direction to therapeutic regimen. • Conducts functional behavior assessments. • Can be episodic or ongoing. • Provides direction for emergency situations. • Documents consultation • Must be child-specific sustained activity greater than 15 minutes in duration.
Treatment Consultation: Occupational, Physical, & Speech Therapies	Occupational, Physical or Speech Therapist	• Licensed OT, PT or SP with established competency in working with children with special health care needs	Where applicable, Minimum 2 units per month Maximum 4 units per month	• Writes OT, PT, SP goals and objectives for treatment plan, in coordination with child's IEP or IFSP. • Instructs home-based workers on proper implementation of treatment interventions. • Observes home-based workers treating the child on a monthly basis. • Documents consultation. • Must be child-specific sustained activity greater than 15 minutes in duration.
Clinical Supervision for Home-Based Worker	Clinical Supervisor	• Licensed health-care professional with established competency in working with children with special health care needs * • Masters or Doctoral degree • Individuals operating under DHS-authorized exception	Minimum 2 units per week Maximum 4 units per week	• Individual or group supervision if more than 2 home-based workers working with child. • Responsible for the development of Treatment Plan and writing of goals and objectives. • Instructs home-based workers on proper implementation of treatment interventions. • Observes home-based workers treating the child on a monthly basis. • Provides direction for emergency situations. • Documents supervision. • Must be child-specific sustained activity greater than 15 minutes in duration.
Child Specific Orientation for Newly Assigned Home-Based Worker	Treatment Consultant Clinical Supervisor Experienced Home-Based Worker	• Licensed health- care professional with established competencies in working with children with special health care needs * • Masters or Doctoral degree OR • Home-based worker with a minimum of 2 years related experience	Maximum two times per child for each Treatment Plan	• Prior authorization required. • Provided one time per child per new worker to prepare home-based workers involved with child. • Can include 1:1 supervision and observing experienced home-based workers treating a child.

Table 4: HBTS Reimbursable Services - continued

HBTS Service Name	Personnel	Qualifications	Approved Units per plan (1 unit=30 minutes)	Comments
Home-Based Specialized Treatment	Home-Based Treatment Worker	• 19 years old; high-school degree or equivalent, minimum 2 years of supervised experience working with children with special health care needs, OR • Associate's degree in human services OR • Currently enrolled in not less than six (6) semester hours of relevant undergraduate coursework at an accredited college or university, OR • As outlined in 6.5.2.1.2, active participation in an agency-specific formal training program, approved by DHS, and successful completion of objective testing within twelve (12) months of hire.	Minimum 10 units per week Maximum 80 units per week	• Intensive treatment provided in the home and/or community setting. • Implement child's individualized Treatment Plan • Home-based worker collects data on responses to interventions for each treatment goal and objective.
Treatment Support	Home-Based Treatment Worker Home-Based Support Worker	• 19 years old, high-school graduate or equivalent, minimum plus 1 year of supervised experience working with children OR • Associates degree in human services	Determined on a case by case basis	• Less intensive services, which provide structure, supervision, guidance and re-direction to a child in the home or community. • Component of direct treatment service plan. • Staff trained on interventions and behavior program used with child. • Data kept during shift for targeted behaviors.
Clinical Supervision of Treatment Support Worker	Clinical Supervisor	• Licensed health- care professional with established competency in working with children with special health care needs * • Masters or Doctoral degree • Individuals operating under DHS-authorized exception	Minimum .5 units every week Maximum 2 units every week	• Individual and/or group supervision. • Review treatment approached to effective methods of responding to challenging behaviors • Reviews changes in treatment plan. • Provides direction for emergency situations. • Documents supervision. • Must be child-specific sustained activity greater than 15 minutes in duration.
Treatment Coordination	Treatment Coordinator	▪ Bachelor's Degree	Maximum 2 units per week	• Activities conducted on behalf of a specific child to ensure coordination with all relevant caregivers and others involved in child's plan of care. • Collects and manages data for summary reports.
Social Skills Group	Treatment Consultant or Clinical Supervisor	• Licensed health- care professional with established competency in working with children with special health care needs * • Masters or Doctoral degree	Maximum twice a week for up to 3 units a session	• Facilitates acquisition of socially appropriate behaviors in group setting • Utilizes recognized curriculum and instructional techniques. • Maximum 8 children with 2 staff.

* In exceptional circumstances, Licensed by Department of Health (DOH) in psychology, social work (LICSW), marriage and family therapist, mental health counselor, and registered nurse with a Masters degree. Competency is established by formal education, continued education credits, internships, work history and supervised practice.

In exceptional circumstances, DHS recognizes that at the beginning of a new plan or during a course of treatment extenuating circumstances may warrant a time-limited increase in Clinical Supervision and/or Treatment Consultation (e.g., discharge from hospital or residential

placement, traumatic events). The provider-agency has the responsibility to document and inform the CFC or DHS of these circumstances and request additional clinical supports. Prior authorization is required from a CEDARR Family Center or DHS.

5.4.1 Clinical Supervision

5.4.1.1 Clinical Supervision of Home-Based Treatment Workers

Clinical supervision is a required component of HBTS. It serves to ensure effective implementation and oversight of the Treatment Plan. It can only be provided by licensed health care professionals, who have competence and experience working with the population being served, unless otherwise approved[10] by DHS. This is evidenced by clinical internship, post-doctoral training, and ongoing continuing education with concentration in areas of study appropriate to the target population (See: Appendix 4).

The services of the clinical supervisor must be documented in writing with respect to date, duration of supervision, which home-based worker received supervision, and reflect sufficient content to substantiate the delivery of this service. Table 5 summarizes the scope and parameters of clinical supervision for the Home Based Treatment Worker.

Table 5: Clinical Supervision for Specialized Treatment

Required Activities	Non-Reimbursed Activities
• Observe worker in the home with the child implementing the Treatment Plan on a monthly basis • Model techniques for staff and/or work with the child • Instruct workers on proper implementation of treatment interventions • Assess efficacy of treatment and address clinical issues • Assist in development/revisions of the Treatment Plan and writing of goals and objectives • Communication and collaboration with others (e.g., school personnel, OT, PT, SP consultants) regarding treatment • Attend IEP or IFSP meetings when appropriate in order to maintain or modify Treatment Plan • In person consultation to home-based worker and family • Provide group supervision when there are two or more home-based workers treating a child. Group supervision is necessary to maintain optimal communication and ensure consistent implementation of treatment.	• Agency administrative meetings • Telephone supervision, except in emergency situations • Telephone consultation • In person or telephone discussions relating to administrative issues • Transportation to and from a child's home is not reimbursed

[10] Variance from licensure is a one time occurrence per individual clinician and subject to the requirements listed in Appendix 4.

Clinical supervision allowed for Specialized Treatment is 1 hour (minimum) to 2 hours (maximum) per week per plan.

Additionally, an individual offering clinical supervision may not also provide treatment consultation. It is required that separate, qualified staff members assume the role of Treatment Consultant and Clinical Supervisor for each case.

It is the responsibility of the Clinical Supervisor to educate the home-based staff on issues of domestic violence, substance abuse and risk to child welfare, harassment of home-based staff or any other serious circumstances that may compromise or interfere with treatment.

5.4.1.2 Clinical Supervision of Treatment Support

Clinical supervision is required to ensure that treatment support provides structure, supervision, guidance, and redirection for children whose developmental condition and level of functioning prevents continuous participation in direct treatment. The amount of clinical supervision allowed for Treatment Support is .5 hour (minimum) to 1 hour (maximum) every week.

Table 6 lists the parameters for the supervision of the Home-Based Support Worker.

Table 6: Clinical Supervision for Home-Based Treatment Support

Required Activities	Non-Reimbursed Activities
• Individual or group supervision • Review changes in Treatment Plan • Address challenging behavior(s) • Review functional domains	• Agency orientation of new staff • Agency administrative meeting • Telephone supervision, except in emergency situations • Telephone consultation • In person or telephone discussions relating to administrative issues • Transportation to and from a child's home is not reimbursed

5.4.2 Home-Based Therapy Direct Services

Specialized Treatment and Treatment Support are provided to a child by a home-based worker (paraprofessional) in accordance with the approved Treatment Plan, and under the supervision of the licensed clinical supervisor.

5.4.2.1 HBTS – Specialized Treatment

Specialized treatment addresses the development of behavioral, communication, social, and functional skills based upon the application of scientifically established procedures from special education, child psychiatry, clinical psychology including behavior analytic therapy, and child development. The focus of treatment can include: increasing language, improving attention to tasks, enhancing imitation, generalizing social behaviors, developing independence skills, decreasing aggression or other maladaptive behaviors, and learning problem solving skills (e.g.,

organization, conflict resolution, and relaxation training). Treatment interventions are provided on a continuous basis in the home and community for an approved number of hours per week.

The home-based worker providing Specialized Treatment is responsible for implementing the Treatment Plan in the child's home and/or community. This individual(s) collect data on responses to interventions for each treatment goal and objective and receive weekly supervision by the clinical supervision and treatment consultation monthly by the physical therapist, occupational therapist and/or speech and language pathologist.

For certain children, it may also be appropriate, when authorized, to include supports for occupational therapy (OT), physical therapy (PT), and/or speech and language therapy (SLP) to reinforce relevant skill development in each of these areas. These support activities can only be considered if the child has a current IEP or IFSP providing OT, PT or SLP.

The goals and objectives included in an HBTS Treatment Plan must be consistent with the goals of the IEP or IFSP. All goals and objectives included in an HBTS Treatment Plan must be based upon the written recommendations from the licensed Occupational Therapist, Physical Therapist or Speech Pathologist consulting to HBTS. Supports are not substitutes for therapy or services provided by licensed therapists in public schools, Early Intervention programs or other settings. No more than 25% of weekly treatment hours can be spent on OT, PT and/or SLP goals.

Related supports and activities may involve:

5.4.2.1.1 Occupational Therapy Support

This service includes goals and objectives and activities to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in home and community settings, (e.g., feeding and eating, toileting, assisting with dressing/undressing, assisting with grooming, oral hygiene, bathing, functional communication, play skills, and community mobility).

5.4.2.1.2 Physical Therapy Support

This service includes goals and objectives and activities to promote sensoriomotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services are for the purposes of increasing functioning during the child's natural activities and routines.

5.4.2.1.3 Speech and Language Therapy Support

This service includes goals and objectives and activities for the habilitation or rehabilitation of communicative or oropharyngeal disorders and delays in development of communication skills. These services are to increase the functional and meaningful communication of the child by engaging in learning opportunities occurring in the home and community settings.

5.4.2.2 HBTS – Treatment Support

Treatment Support is a less therapeutically intensive component of home-based direct treatment services. Treatment Support is provided as a complement to Specialized Treatment. The request to include Treatment Support as part of an HBTS Treatment Plan may be initiated by parents, the provider-agency or a CEDARR Family Center.

The goal of Treatment Support is to assist children with moderate to severe developmental and neuro-medical conditions whose level of functioning limits their participation and ability to engage in sustained Specialized Treatment. Treatment Support is intended to facilitate some children's transition into adulthood by supporting a child's ability to remain at home and to participate in the community. It encourages and facilitates activities of daily living by providing structure, supervision, guidance, and redirection while engaging in cognitive, physical and social activities that would be typical for a child their age. Accordingly, one or more of the following domains must be addressed:

1) Acquiring and using information.

2) Attending and completing tasks.

3) Interacting and relating with others.

4) Caring for themselves.

5) Helping them maintain their health and physical well being including participation in community activities.

Treatment Support can be provided by the same individual providing Specialized Treatment or by an individual who meets the qualifications for a home-based Treatment Support worker. The home-based Treatment Support Worker is trained on interventions and behavioral approaches used during Specialized Treatment. The occurrence of target behaviors will be monitored and recorded during shift hours.

The rationale for seeking Treatment Support must be clearly articulated and linked to its intended purpose and domains of focus. Treatment Support services are not for the convenience of others or to be substituted when other more appropriate services are indicated (e.g., respite, certified nursing assistance, or child care).

5.4.3 Child Specific Orientation for Newly Assigned Home-Based Workers

The State recognizes that for various reasons, HBTS provider-agencies may experience staff turnover and need to recruit new home-based workers to implement Treatment Plans (i.e., Specialized Treatment and Treatment Support Workers). A newly assigned staff person is expected to be knowledgeable about a child's condition, treatment approaches and past treatment history. Child Specific Orientation assures that the home-based worker is prepared to carry forward the goals, objectives and techniques of the child's specific Treatment Plan.

DHS regards the effectiveness of treatment to be related to the availability and continuity of treatment staff. It is the responsibility of the provider-agency to ensure that newly assigned workers are ready to provide child specific treatment by arranging for a period of Child Specific Orientation. The clinical supervisor is responsible for overseeing Child Specific Orientation. The clinical supervisor or treatment consultant, as identified in the Treatment Plan, provides the orientation with the assistance of an experienced home-based worker.

DHS requires provider-agencies to submit a request for Child Specific Orientation as part of an approved Treatment Plan and proposed budget. The provider-agency may utilize this service if it becomes necessary and clear documentation of the service must be maintained. The frequency with which this service is utilized will be monitored. DHS will reimburse Child Specific Orientation for newly assigned staff a maximum of two times within an authorized period of treatment for each child's Treatment Plan. Each orientation session may include more than one staff member assigned to a specific child..

5.4.4 Social Skills Group Therapy

Social skills therapy facilitates the acquisition of socially appropriate behaviors (e.g., social entry, conversational skills, conflict resolution, and anger management) and foster more consistent social functioning in other settings (e.g., neighborhood or community settings). This therapeutic service is conducted in a group setting and uses recognized curricula and instructional techniques. Group therapy can only be provided by a licensed health care professional.[11]

5.4.5 Treatment Consultation

Expert consultation is provided to the treatment team by a licensed health care professional with recognized expertise in the specific area of the child's needs. Treatment consultation services may focus on Treatment Plan implementation, response of the child to the therapy, approaches to understanding and addressing emerging issues in the course of treatment, and adjustment to treatment mode. Treatment consultation is intended to bring specific expertise and direction to the therapeutic regimen employed in the Treatment Plan. This service can be episodic to address particular issues or concerns, or ongoing through a child's Treatment Plan. The treatment consultant may not simultaneously provide clinical supervision to a case, provided however that a Treatment Consultant may be used to provide supervision and oversight to non-licensed clinical staff, as described in 2.7.1 and in Appendix 4, but their services are not additionally reimbursable when acting in that capacity. Transportation to and from a child's home is not reimbursed.

[11] Reimbursement must be first accessed through a child's health insurance such as Rite Care or commercial health insurance, if available. If the primary insurer denies group therapy, the provider-agency must notify DHS or CEDARR Family Center in order for the social skills group to be authorized and reimbursed by DHS.

5.4.6 Treatment Coordination

This service is provided by a team member on behalf of a specific child receiving HBTS services to ensure coordination with parents, other providers or agencies directly involved with the provision of services to the child. Service activities can include gathering child specific information to facilitate HBTS, direct communication with other service providers regarding the child, and communications with parents, the "medical home", and/or primary care provider.

Treatment coordination does not include supervision or other clinical responsibilities.

The concept of the "medical home," as put forth by the American Academy of Pediatrics (November, 1992) recognizes that the medical care of infants, children and adolescents should be directed and, when appropriate, delivered by well-trained physicians who are able to manage and facilitate all aspects of pediatric care. It is therefore imperative that an HBTS provider-agency facilitate and maintain timely communication with a child's pediatric primary health care provider during a course of HBTS intervention.

5.5 Treatment Intensity of HBTS and Therapeutic Approaches

Treatment intensity refers to the number of direct service hours in an approved Treatment Plan. Treatment intensity requires continuous monitoring to ensure its appropriateness during an authorized period of care. It is the provider-agency's responsibility to justify that the level of treatment intensity is necessary to promote the achievement of treatment objectives.

Treatment intensity is individually determined and based on a comprehensive assessment of a child. Relevant background information shall include previous evaluations, IEP, IFSP, treatment summaries, recommendations from current providers of care, and ~~in consultation~~ collaboration with the child's family. The scope of interventions including treatment intensity should be appropriate to the child's needs and learning style. Many factors influence decision making when considering treatment intensity. Arriving at an appropriate level of treatment intensity must take into account the following factors:

(a) The child's age

(b) Ability to engage in sustained treatment (e.g., span of attention, stamina, developmental level, etc.) and expectations for progress

(c) Type, nature, and course of presenting condition and diagnosis

(d) Severity of presenting behaviors

(e) Impact on family functioning

(f) Presence of co-existing conditions

(g) Presence of biological or neurological abnormalities

(h) Current functional capacities of the child;

(i) Family factors (e.g., parenting skills, living environment, and psycho-social problems)

(j) Interaction with other agencies or providers

(k) Other treatment or educational services being received

(l) Appropriateness for Treatment Support

Overall, there is no single treatment approach indicated for the population of children eligible to receive HBTS. Additional information about treatment approaches is presented in Appendix 8. Successful treatment is more involved than just the number of treatment hours provided per week for a child and family. The most successful treatment models combine structured lessons, informal instruction, practice and reinforcement with respect to skill development.

The responsibility for approving a treatment proposal rests with DHS or a CEDARR Family Center. The clinical review process takes into account all of the above information. When a treatment proposal is approved, the HBTS Treatment Plan provides the basis for defining treatment interventions and addressing treatment goals and objectives.

5.6 Duration and Continuation of Service

For a Medicaid eligible child under 21 years of age, there is no limit to the number of HBTS Treatment Plans that may be approved for an individual child. Treatment is provided on a weekly basis for an approved number of hours for a period of six months. Treatment Plans may be modified based on formal action by the CEDARR Family Center or DHS following consultation with the provider-agency and approval from the family.

5.6.1 Categories of Treatment Requests

5.6.1.1 New HBTS Treatment Plans

A new Treatment Plan is defined as *either* a Treatment Plan written for any child when there is no history of HBTS or ~~is~~ the first HBTS Treatment Plan written for a child by a particular provider-agency. Refer to section 5.11.

5.6.1.2 Reauthorization of Treatment Plan (Renewals)

A reauthorization request is for HBTS to continue for an additional six-month period of time with the current provider-agency. This proposal includes the results of treatment gains on particular goals and objectives during the past six-months. See section 5.11 for procedural directives.

5.7 Family Involvement and Responsibility

HBTS is a home and community based service through which a child and family are provided treatment services. These standards identify a series of requirements for certified provider-

agencies with regard to areas such as family-centered care, communication and coordination with the family. Parents have the right to refuse a home-based worker from treating their child at any time during the course of treatment.

Provider-agencies should reasonably expect that families will recognize and respect the roles and responsibilities of providers. In order for HBTS to be effectively and safely provided, the family must be able to ensure that the care setting is safe and that family members will work positively with the provider-agency in maintaining a collaborative care relationship. The HBTS provider-agency must guide and assist their staff in the delivery of comprehensive, coordinated family-centered care, and has the responsibility for creating a climate which is responsive to the child's and family's needs, and supportive to its personnel. Provider-agencies must recognize that HBTS staff is in the home to provide services in accord with an authorized Treatment Plan and not to provide other home support services (e.g. cleaning, cooking, running errands, child care for siblings).

A commonly raised issue in home-based services is whether the parent or an adult family member must be present in the home when services are being provided. First, each provider-agency has the responsibility to determine with the family, the amount of time a parent is required to be physically present while services are being provided in the home. This is an issue of liability for both the provider-agency and family. DHS expects the level of parental presence to support the accomplishment of treatment objectives. In most cases this may require parents to be present in the home during HBTS a majority of the time (See: Appendix 9). A parent or "caretaker" must be in the home if siblings requiring supervision are present.

A related issue of a parent designee representing the family during HBTS activities may be allowable but is up to the discretion of the provider-agency. This will be determined on a case-by-case basis.

Second, regarding parental participation, an important objective of HBTS is for parents to be able to safely and satisfactorily address their child's behaviors and special needs while living at home. Expectations regarding family presence and parental participation must be included in the HBTS Treatment Plan developed for any treatment period.

Upon initiation of services, families must be provided with a copy of any policies regarding suspension or discontinuation of HBTS. Then, if services are provided in the home and the family does not provide an appropriate environment for care, the services may be suspended until a review of the Treatment Plan can be scheduled with the notification to the CEDARR Family Center or DHS personnel. Examples of such circumstances include presence in the home of dangerous weapons, illegal drugs, excessive use of alcohol, domestic violence, verbal abuse of HBTS workers, or significant failure of the family to participate with the providers in the Treatment Plan. Appendix 10 provides further direction and requirements of provider-agency responsibilities for handling such circumstances.

5.8 Transportation

Transportation during the course of HBTS may be provided by the home-based worker. However, the State will not assume any liability or responsibility for these activities. Any transportation provided to an outside program, facility or activity must be related to a Treatment Goal, which has been approved by a clinical reviewer (i.e., CEDARR or DHS). DHS will not approve 2:1 coverage during transportation except under extremely unusual and time-limited situations subject to prior approval from DHS or CEDARR. Specific requirements for the Transportation policy are outlined in Section 7.7.1. Provider-agencies are required to inform families of this policy and obtain the necessary documentation and parent/guardian signatures prior to providing any transportation.

5.9 Management of Current HBTS Waiting Lists

Every HBTS provider agency must submit a copy of its up to date, accurate waiting list, on or before October 15, 2002. The list should be in alphabetical order.

After October 15, 2002, HBTS agencies should no longer place families on a waiting list. Families seeking HBTS should be directed to a CEDARR Family Center.

Families on waiting lists submitted to DHS by October 15, 2002 may continue to seek new treatment plans directly from the HBTS provider.

The provider-agency has the responsibility to ensure that families on a waiting list will be informed of their status and the availability of services on a quarterly basis. This also includes updating a family's commitment to remain on the waiting list and the urgency of need for HBTS. As a result of this information the provider-agency may need to re-assign waiting list positions after a clinical supervisor or treatment consultant has reviewed all information and has conferred with the child's family and involved any relevant parties providing services to the child. This may result in a referral for other services that would meet the child's needs~~,~~ or an emergency triage through the child's health plan.

All other families seeking initiation of HBTS through a CEDARR Family Center, which will do an intake assessment, develop a Family Care Plan and will be responsible for assisting the family to obtain HBTS.

For all new treatment plans commencing January 1, 2003 the prior approval will be issued by the CEDARR Family Center.

DHS will continue to review and author all renewal requests until further notice, except for those plans which were originally authorized by a CEDARR Family Center.

5.10 Compliance with Other DHS Procedural Directives[11] for HBTS

1) It is expected that parents are involved in the development of all Treatment Plans with the provider-agency well in advance of the date the Treatment Plan is to be submitted. Provider-agencies shall allow parents sufficient time to review the Treatment Plan (minimum of five (5) calendar days) prior to submitting it to DHS or to a CEDARR Family Center. During this time, parents should have the opportunity to meet with the treatment team to discuss any questions or concerns they may have regarding their child's treatment.

2) For Treatment Plans requesting reauthorization of services the following information should be included:

    a) HBTS history

        i. Dates of service for all previous HBTS plans

        ii. Number of direct service hours approved for entire authorized treatment period. (Direct service hours include specialized treatment and treatment support services)

        iii. Total dollar amount of each plan

    b) For the most recent plan include the percentage of direct service hours delivered compared to the total number approved. For example, if 10 hours a week were authorized for 6 months, the total would be 260 hours (10 hours times 26 weeks). Sum all direct service of treatment hours delivered for the 6-month period and divide that by 260. To get a percentage multiply this number by 100.

3) For each plan, include a schedule of the days and times services will be delivered.

4) For billing issues DHS policies require the following:

    a) If no direct service treatment hours were provided to a child during an authorized month, providers may not bill for Treatment Consultation or Clinical Supervision without written approval from DHS or a CEDARR Family Center.

    b) It is recognized that the delivery of treatment hours can vary in a given month due to extenuating circumstances. However, it is the responsibility of the provider-agency to ensure that clinical supervision, treatment consultation and treatment coordination continue based upon the level of treatment hours delivered that month.

[11] Prior to the development of these standards, DHS provided written memoranda to existing HBTS provider-agencies clarifying its policies. All applicants are required to be aware and informed about these policies as summarized in this section.

i. If fewer than 75% of direct treatment hours were provided in a given month, no more than an equal percentage of clinical supervision and/or treatment consultation hours can be billed for reimbursement.

ii. If 75% or more of the direct treatment hours were provided for a given month, all approved numbers of clinical supervision and/or treatment consultation may be billed.

5) DHS has received requests for 2:1 staffing for some of the time HBTS workers work with a child. DHS does not fund these requests except under extremely limited conditions and for only a short-term period (i.e. up to one month). If a child requires a 2:1 staff ratio to safely participate in community/out-of-home activities, then either a family member or another adult appointed by the parents is responsible to provide this assistance. If this is not available, in order to assure safety, the child will need to refrain from community-based activities until his/her behavior will allow safe participation with only 1:1 staffing. The Clinical Supervisor, Consultant or Director of the HBTS program should make this determination for the Agency.

6) HBTS is frequently requested for children for whom professional mental health services are clearly needed but are not being provided for a variety of reasons. For these children, HBTS can serve as a useful and beneficial adjunct to therapy, but is not to be used as a substitute for professional counseling. The HBTS provider-agency should assist families, as needed, to identify a suitable therapist, and assist with scheduling these services and therapy appointments. This assistance and support should be documented in the Treatment Plan and daily progress notes kept by staff. DHS or CEDARR clinical reviewers may decline to approve plans when therapy is clearly needed and not being provided.

7) Parents are required to participate in the development of and to approve all initial and renewal Treatment Plans. It is recommended that provider-agencies create a separate page that includes a statement indicating that the parent has reviewed the Treatment Plan, the hours requested and that they agree with the content of the plan. Provider-agencies are to have the parent sign and date this page and include it in the Treatment Plan.

8) If a provider-agency wishes to change the services within the approved treatment period, an addendum to DHS and/or the CEDARR Family Center indicating the reasons for the change, new goals and objectives, a revised budget sheet and a signed parent signature form must be submitted. Requests will only be processed after all documentation has been received.

9) Both initial and renewal Treatment Plans are to be submitted a minimum of 30 days prior to the date anticipated services are to begin.

10) Two sets of each Treatment Plan – one original and one copy of the full proposal must be included. Documents in the following order are to be submitted.

i. New Data Sheet
ii. Prescription from medical doctor (MD)
iii. Parents' signature approving plan
iv. Budget Sheet
v. Treatment Plan including goals and objectives
vi. Accompanying information (e.g., IEP, assessments, letters)

11) Any additional information requested by DHS or the CEDARR Family Center clinical reviewers must be responded to in writing within 9 calendar days upon receiving the request to avoid delaying authorization of services. Responses to reviewer's comments are to be provided using a separate sheet of paper for each response. Two copies should be included**.** Late responses may result in loss of funding for the period affected by the delay.

12) Unless requested by DHS, as of January 1, 2003, providers will not be required to submit monthly Invoice Documentation Sheets for each child, listing the direct and indirect services provided that month.

13) New Treatment Plans need an EPSDT prescription form completed by the child's primary health care provider (MD) or child's psychiatrist.

14) General Medicaid policy states that claims must be filed with EDS within 12 months of the date of services.

5.11 HBTS Service Performance Standards

5.11.1 Timeliness of Service Provision

In order to adequately meet the needs of children and families, HBTS must be provided in reliable and timely manner given the following requirements:

1) A CEDARR referral or family initiated contact must result in the provider-agency establishing an intake appointment. This face-to face meeting must occur within three weeks of the initial contact.

2) The purpose of the intake appointment(s) is to review the CEDARR Family Care Plan with the family, introduce the family to the provider-agency's treatment orientation and approach, gather information regarding targeted behaviors, and arrange for observations at home, school and/or community settings. This is an initial meeting to establish a therapeutic working relationship with the child's family. As such, it is an opportunity for parents to ask questions regarding the provider-agency's HBTS program, parental involvement, and treatment expectations. Parents are to be provided with written information regarding HBTS and related policies such as client rights, transportation and grievance procedures.

3) The provider-agency must develop and submit the Treatment Plan for review and authorization by the CEDARR Family Center within four (4) weeks of the initial intake appointment. This Treatment Plan is focused on goals and objectives, as recommended by the CEDARR Initial Family Assessment or Family Care Plan.

4) When developing a Treatment Plan for a CEDARR Family Center or DHS, the provider-agency must fully staff a proposed level of treatment intensity within four weeks of the authorization date to start HBTS. The Treatment Plan must reflect the ability of the provider-agency to staff a child's plan.

5.11.2 Parent Satisfaction

Routine and consistent parent feedback is an important aspect of quality assurance. HBTS provider-agencies shall design survey instruments to generate information for activities related to parent satisfaction with provider-agency services, accessibility, availability, and overall level of satisfaction. Section 6.5.5 provides further elaboration and direction. Parent/guardian information is strictly confidential.

5.11.3 Provision of Authorized Services

Certified HBTS provider agencies are expected to provide the service hours included in an approved treatment plan. However, the State recognizes that, for various reasons~~,~~ including those related to staff capacity and availability of the child and family to engage in services, HBTS provider-agencies may not be able to successfully provide services for all authorized hours during a period.

Fully certified providers will be in compliance with the Certification Standards and meet performance standards. The performance standard for this Certification Standards is that an HBTS provider agency must provide at least 75% of authorized direct service hours to at least 90% of children in their caseload. Providing at least 75% of authorized direct service hours to less than 90% of children in their caseload in any ninety (90) day period may result in the provider agency receiving a Provisional Certification status.

6. CERTIFICATION STANDARDS

6.1 Requirements for Organization of Delivery of Service

An applicant for certification must demonstrate that it brings to the clinical program a sound combination of clinically proven treatment approaches, clinical management, skills and experience, and the capability to reliably provide HBTS.

Section 6 and 7 identify the requirements which must be addressed in a certification application. Applicants are to describe their approach to meeting these requirements. Further guidance as to how to complete the application is included in Attachment A, Application Guide.

6.2 Agreement to Accept Appropriate Referrals

Based on their clinical expertise and experience, certified HBTS provider-agencies will be expected to accept all appropriate referrals of Medicaid enrolled children who are determined to be eligible for HBTS~~,~~ and to provide services on a timely basis as defined in Section 5.12.1 of these Certification Standards. Provider-agencies are allowed to decline to submit a Treatment Plan when they determine that their agency cannot meet the child's needs or HBTS is not an appropriate program for the child. Reasons might include lack of staff availability, lack of experience with a particular treatment condition, or geographic limitations. Documentation of the reason for declining to provide a treatment plan shall be maintained.

Providers are not required to accept referrals that involve Treatment Plans that include Treatment Support.

6.2.1 Provision of Authorized Services

Certified HBTS provider-agencies are expected to consistently provide the service hours included in an approved Treatment Plan. However, the State recognizes that for various reasons, including those related to staff capacity and availability of the child and family to engage in services, HBTS provider-agencies may not be able to successfully provide services for all authorized hours during a period. The performance standard for a certified agency is that an HBTS provider-agency must provide at least 75% of authorized direct service hours to at least 90% of children in their caseload for a period of three (3) consecutive calendar months.

6.3 Family Centeredness, Client Rights and Ethical Standards of Practice

6.3.1 Family Centeredness

HBTS provider-agencies must incorporate key components of family-centered care into their philosophy, service program and operations. Applicants must demonstrate the manner in which important principles of family-centered care are part of their approach to services. Areas of program policy shall include, but are not limited to, the following:

1) Established arrangements for ongoing communication with, and participation of the family in all aspects of the treatment program.

2) Policy setting forth the degree and character of family involvement in care planning.

3) Standards for working with family and the care-givers to help them safely maintain the child at home.

4) Policies setting forth emphasis on family-centered service outcomes.

5) Description of service arrangements flexible enough to meet special and individual needs.

6) Demonstration of approaches to assuring families are encouraged to voice concerns and provide input

6.3.2 Client Rights and Family Service

Families must be informed of client rights, the expectation for their participation in treatment plan development, treatment modifications, and problem-resolution processes prior to the establishment of a Treatment Plan. The HBTS provider-agency shall have an established approach to ensure that this communication is maintained throughout the course of care. In this regard, the provider-agency shall have established policies, procedures and related records to ensure focus on customer service, solicitation of family input, documentation of and response to complaints, and prompt complaint resolution. This means being able to address complaints from parents, or recipients of HBTS, as well as staff working for the agency.

The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral for services.

Provider-agencies shall also have written protocols as to how changes in service hours occasioned by changes in staffing will be communicated to families, including what accommodations will be offered in the event that service hours will be reduced. In the event that a provider-agency has elected not to accept *new* referrals that involve Treatment Plans that include Treatment Support, the agency shall also have written protocols that address circumstances where Treatment Support is elected by families in their *current* caseload.

Written materials shall be provided to families identifying the circumstances under which a Treatment Plan will be discounted by the Agency. The provider agency shall communicate with the family the reasons for requested termination and communicate with the CEDARR Family Center or DHS (see Sections 4,2.3 and Appendix 10).

Appendix 10 provides additional information and requirements pertaining to provider-agency responsibilities for suspension or discontinuation of HBTS.

In the instance of a provider-agency termination of care, not as a result of safety risks to the home-based worker, written notification shall be sent to the child's family or guardian, as well as

DHS or CEDARR Family Center 30 days prior to discontinuing HBTS. Reasons for discontinuing treatment must be stated. Alternative resources, and /or referrals, if appropriate, must be given. The provider-agency must set forth its policies and procedures regarding termination of services for non-safety concerns.

The provider-agency shall have in place procedures for dealing with risks and safety to the well-being of the home-based staff. In such circumstances, immediate suspension or termination of care may be necessary with immediate notification to the family, DHS and the CEDARR Family Center. See Appendix 10 for additional information.

The provider-agency shall have an established approach to ensure that client rights are clearly stated and communicated. Practices shall include maintaining written policies and procedures, as well as materials provided to families at the onset of care and periodically. Written materials shall also be provided to families identifying the circumstances under which a Treatment Plan will be discontinued.

A parent or guardian has the right to terminate HBTS at any time.

6.3.3 Ethical Standards

Clearly articulated Principles of Ethical Care and Professional Conduct must be publicly posted. Protocols will identify standards of ethical practice for staff. The latter shall include, but will not be not limited to, the following issues:

1. Crisis intervention and management of emergency situations (i.e., family or staff)
2. Client and professional boundaries
3. Grievance policies and procedures
4. Use of aversive behavior modification techniques (including use of restraints)
5. Written description of services provided

6.4 Coordination and Communication with CEDARR Family Centers

CEDARR Family Centers provide information and support services to families of children with special health care needs (CSHCN). Linking families to appropriate resources (e.g., clinical specialists or services) and providing care coordination are central aspects of the CEDARR system of care.

From the outset, the CEDARR Family Center works with the child and family to assess current circumstances, continuing needs, and reasonable next steps. Upon completion of an Initial Family Assessment (IFA) and clinical specialty evaluations, if indicated, a CEDARR Family Care Plan (FCP) is developed. Continuing Family Care Coordination services may be included in the plan, as appropriate. The plan may include CEDARR Direct Services and Supports. HBTS may be one of these Direct Services, if the family concurs. In this case, the CEDARR Family Center will provide the family with information about certified HBTS agencies. The

family and/or the CEDARR Family Center will schedule an intake appointment with the agency it chooses. The CEDARR Family Center will help coordinate arrangements for all Direct Services and Supports. It is anticipated that in the majority of cases, the CEDARR Family Center will continue to work with the family to support efforts to gain access to needed services and to track receipt of services and progress in meeting stated goals and outcomes. CEDARR Family Centers are responsible with the family to determine the types of service, intervention needed, the intensity of services, the required outcome of services, the appropriate approach to service intervention, and to recommend to DHS, the authorization of service type, intensity, duration, and obtain prior authorization.

The HBTS provider-agency has the obligation to maintain communication with families and CEDARR Family Centers. Based on these communications, information is provided to the family about any projected waiting period that could delay the start of services. With this information, the family is better able to exercise informed choice regarding its preferred provider. The HBTS provider-agency must comply and adhere to communication and coordination requirements with CEDARR Family Centers.

A provider-agency seeking to offer HBTS must describe its processes to ensure coordination and communication with all CEDARR Family Centers. An applicant must demonstrate that it can work with CEDARR Family Centers and that it understands the role of the CEDARR Family Center in working with families. The HBTS provider-agency must be cognizant of processes and be responsive to a CEDARR Family Center in the following areas:

1) Accept referrals and information;

2) Provide Treatment Plans to CFC;

3) Provide feedback regarding progress toward goals;

4) Inform CFC in writing of changes in the child's needs or ability of HBTS provider-agency to meet direct services hours, goals and objectives identified in the CFC Family Care Plan and the HBTS Treatment Plan.

The provider-agency must demonstrate in its application that it has a process of communication with the CFC to ensure that this coordination will be in place.

6.4.1 Initial Referral to a CEDARR Family Center

Initial referral to a CEDARR Family Center of potential candidates for HBTS may occur in one of several ways:

- Family referral
- Referral from a medical provider (e.g., primary care provider, other medical specialist, or mental health clinician, etc.)
- Referral from a Medicaid Managed Care Health Plan
- Community referral (e.g., community mental health center, school, EI, CASSP, DCYF)

- Hospital or residential level of care referral
- Referral from an HBTS provider

All referrals for HBTS will be evaluated by a CEDARR Family Center. With the consent of the family, the CEDARR Family Center will engage the family in evaluating the needs of a child, which could include Home-Based Therapeutic Services. The HBTS provider-agency must work directly with all CEDARR Family Centers regarding prior authorization of new services, renewal of services, and communication of progress. All time line expectations of DHS are to be applied and followed when working with CEDARR Family Centers. Applicants must describe their understanding of these arrangements, describe how they will interact with CEDARR Family Centers, and report on their initial contacts with CEDARR Family Centers (See Appendix 16).

6.4.2 CEDARR Family Center Initial Family Assessment (IFA) and Basic Services

The goal of the IFA is to develop a working profile of the family that forms the foundation for the assessment. The assessment includes: an assessment of urgency, a developmental and diagnostic history (including physical health, behavioral health and cognitive development); an analysis of current interactions with the care system (e.g., RIte Care, pediatrician, specialist, hospital, or other provider); involvement with other programs (e.g., Early Intervention, Medicaid, RIte Care, or school programs); family strengths, needs and supports; knowledge of or linkage with advocacy groups or professional associations; current insurance status and needs; and potential eligibility for various public programs or community supports.

6.4.3 CEDARR Family Center Care Plan

On the basis of the IFA, the Family Care Plan (FCP) will be developed in concert with the family. The Family Care Plan may result in possible referrals and/or services, which could include:

- Home-Based Therapeutic Services
- Pediatric Home Care
- Early Intervention Services
- Special Education Services
- Therapeutic Services in Child and Youth Care (when available)
- Personnel Assistance Services and Supports (when available)

The Family Care Plan for an individual child may include a combination of these and/or other services.

Where Home-Based Therapeutic Services are selected and the family has selected a preferred provider-agency of these services, the CEDARR Family Center will make a written referral to a certified HBTS provider-agency of these services. The referral will include:

1) Initial determination of need and scope of treatment (i.e., Specialized Treatment and Treatment Support).

2) Projected number of hours per week of HBTS.

3) Expected duration for the service (Note that six months is the maximum period for a Family Care Plan before a plan review, revision and reauthorization is required).

6.4.4 CEDARR Family Center Certified HBTS Treatment Plan

The referral from the CEDARR Family Center provides the initial information noted above. The CEDARR Family Center will provide materials from its own assessment to avoid duplication of effort by the HBTS provider-agency and recommendations for intensity of treatment hours. Next, the HBTS provider-agency will perform a more focused assessment directed toward determining the specifics of the Treatment Plan and the appropriate arrangements for actual provision of services. This Treatment Plan will detail treatment goals and objectives, schedule of service, approach to working with the family and other relevant considerations. In turn, the Treatment Plan is submitted to the CEDARR Family Center for clinical review.

The CEDARR Family Center has the authority to approve, reject or request modification to the provider-agency's proposed Treatment Plan. Once approved by the CFC, its recommendation for authorization is then transmitted to DHS and to EDS, and it is included in the finalized Family Care Plan.

6.4.5 CEDARR – HBTS Provider-Agency Dispute Resolution Process

The CEDARR Family Center and the provider-agency shall have established procedures to identify and resolve differences, and demonstrate how families will be informed with respect to the following occurrences:

6.4.5.1 HBTS Provider- Agency and CEDARR Family Center Disagreement Process

In the event of disagreement regarding elements of the Treatment Plan (e.g., treatment interventions and methods, focus of treatment, involvement of parents or collaterals, or treatment intensity), it is anticipated that the parties can reach resolution in most cases through joint review and discussion. Where resolution cannot be achieved, a request can be made to the Department of Human Services for an independent clinical review. After this has been done, the prior authorization necessary for claims to pay will be entered by the CEDARR Family Center or DHS.

6.4.5.2 DHS Fair Hearing Process

If a child's parents or guardian objects to the decision of the CEDARR Family Center or DHS they can request a hearing. An Administrative Fair Hearing allows for testimony to be presented from all concerned parties. In turn, the Hearing Officer renders a written decision. Upon completion of this process, the prior authorization necessary for claims to pay may be adjusted based on the hearing decision.

Rules and procedures for requesting a Fair Hearing are as follows with related information provided in Appendix 11:

1) The recipient's parents or guardian will receive written notification of the approved Treatment Plan following the second independent clinical review.

2) If the parents or guardian disagree with the results of the clinical review, they have ten (10) days from the date of authorization to file a request for a Hearing.

3) If a request for a fair hearing is received by DHS within ten days, there will be no modification to the number of requested direct service hours until the conclusion of the Hearing. During this time, the provider-agency may submit claims for payment of services, as the proposed Treatment Plan in dispute remains in effect.

4) If a request is received after ten days, the approved number of direct service hours will stand until the conclusion of the Hearing. Claims will be paid in accordance with prior authorization.

5) Hearing decisions may be appealed with the Superior Court within 30 days of the date of the hearing decision pursuant to Rhode Island General Laws 42-35-1 et seq.

6.5 Strength Of Program Approach: Process of Care and Management of Clinical Services

The applicant must demonstrate that it brings a sound combination of experience and skills to be certified as an HBTS provider-agency. The provider will use written standards of care to describe the process by which treatment is planned, delivered, monitored and evaluated. There will be evidence of initial and on-going involvement of family members. The applicant will ensure that staff has appropriate competencies, educational preparation, and clinical experience to engage in the delivery of HBTS.

In describing its program, the applicant will address the areas identified below:

6.5.1 Process of Care

The provider will demonstrate that the care process is systematically organized and grounded in sound clinical principles. In section 6.4.1, the applicant will describe its clinical model and policies and procedures for the provision of HBTS. In doing so, the applicant should address each of subsections 6.4.1.1 through 6.4.1.5.

6.5.1.1 Treatment Approach and Clinical Guidelines

Clinical guidelines will permit diversity and flexibility while promoting the best possible outcome for each child. The clinical guidelines must address screening and intake, assessment and treatment planning, treatment plan implementation, and treatment plan monitoring and

modification. Written standards of care, policies and procedures will be in place for all levels and aspects of HBTS.

The applicant must describe the treatment approach used and the range of conditions for which the treatment approach is considered to be efficacious using clinically proven interventions. DHS reserves the right to have evidence-based information presented to support proposed clinical interventions. The applicant should clearly identify the guiding principles that govern the treatment program and their basis in empirical literature and/or nationally accepted practice standards. Sound clinical and program management are required.

The applicant must provide evidence of satisfactory written and professionally recognized clinical practice guidelines along with identification of how adherence to such guidelines is systematically monitored.

6.5.1.2 Screening and Intake for HBTS

Applicants must have an organized process for handling referrals; for screening and intake; and for determining the appropriateness of the services of this agency for a child and family.

Screening and intake must be based on written policies and procedures that clearly define admission criteria and program services. These policies must ensure that contact with a family respects the family's privacy, and is conducted in a culturally sensitive and family-centered manner.

The applications for certification must include written policies and procedures for addressing the following:

1) Managing referrals.
2) Screening and intake.
3) Eligibility and admission criteria.
4) Management of direct services
5) Management of current waiting list and communication with families.
6) Assisting families not eligible for HBTS by providing alternative recommendations.

A documented written record of the intake is to be maintained.

6.5.1.3 Assessment and Treatment Planning

There shall be a thorough identification of the specific problem(s) to be addressed. Components of the assessment shall be identified (e.g., communication with the CEDARR Family Center, parent interview, child observation, conversations with school representatives, collaboration with other health care providers, and review of past evaluations).

For non-CEDARR Family Center referrals, the IEP, 504 Plan or Individual Family Service Plan (IFSP) and any other evaluations or treatment materials should be attached and the assessment should identify the services being received through the schools or Early Intervention programs. Problem behaviors should be identified with the order of importance or priority indicated.

The involvement of the family and the preparedness of the family (including extended family and/or other potential caretakers) to participate in treatment shall be indicated. Unless exceptional circumstances are identified, this will include both parents even if they are not living together.

All requested documentation shall be obtained solely by parental written consent and all records shall be maintained to ensure their security and confidentiality.

As part of the assessment, licensed clinical staff should complete the Global Assessment of Functioning Scale (GAF) taken from the Diagnostic and Statistical Manual IV (DSM-IV). The Global Assessment Scale for Children (See: Appendix 12) may be used in its place.

6.5.1.3.1 Diagnosis and Treatment History

The child's diagnosis (DSM IV or ICD-9) must be clearly identified. Documentation shall identify who made the diagnosis, the basis for the diagnosis, when the diagnosis was made, and its current status. Treatment information is to be updated for any period of authorized care.

The approved Treatment Plan shall include information on the services that have been provided previously. Information should be present regarding any other providers that have been involved with the child and family (e.g. child psychiatrist), other treatments that have been tried or considered, and the sequence of events leading to the submission of the HBTS request. This should also include information regarding other Medicaid funded services such as Pediatric Home Care, other CEDARR Direct Services, and all CEDARR Family Center Services, when appropriate.

6.5.1.3.2 Treatment Plan Development

The applicant will describe the provider agency's specific protocols for the development of the Treatment Plan. Protocols will identify the provider-agency's overall approach and address each of the following:

1) The identification and prioritization of treatment goals and objectives shall be clearly based on the assessment. Goals and objectives for each identified problem must be realistic, specific and measurable. There must be clear written criteria that define the anticipated level of achievement for each goal and objective.

2) A brief description of treatment interventions for each identified problem shall be included.

3) The provider-agency will adhere to appropriateness criteria for admission to HBTS. It is critical to identify in detail if and why a child is at risk for inpatient hospitalization or out-of-home placement, as well as how the proposed HBTS services will address each identified problem and risk factor.

4) The parental level of participation in the Treatment Plan must be identified. The plan may include a parent consultation component (i.e., behavior modification techniques, conflict resolution, information on child development) and a support component (e.g., referral for additional support or treatment for the child and family).

5) The Treatment Plan shall meet the criteria for Family-Centered Care (See: Section 1.4).

6) The parent/guardian/legal custodian must sign the proposed Treatment Plan.

7) The number of weekly treatment hours shall be clearly explained and justified in detail.

8) The Treatment Plan shall indicate the anticipated length of treatment and the method for measuring progress towards obtaining the stated goals including discharge criteria.

A Treatment Plan for HBTS must present goals that are specific to the child's diagnosis and presenting problems. The following must be done:

1) All treatment interventions, including those addressing OT, PT and SLP goals and objectives, must be identified and described in detail. This means defining treatment methodologies (e.g., applied behavioral analysis, contingent time-out, response cost, schedules of reinforcement, social stories, modeling, etc.) linked to clearly defined goals.
2) Goals must be written in behavioral terms with well-defined objectives. Goals are broad, generalized statements about what is to be learned within the 6 month period of treatment.

3) Objectives are specific, measurable, short-term, observable behaviors. Objectives are the foundation upon which lessons and assessments are built ~~which will~~ to meet the overall treatment goals. The objectives should include:

- **A**udience: Who is this aimed at?
- **B**ehavior: What is expected that the child will be able to do?
- **C**ondition: How? Under what circumstances will learning occur?
- **D**egree: How much? Must set the specific criteria to be met.

6.5.1.4 Treatment Plan Implementation

The applicant shall describe how it will provide effective, efficient, high quality treatment on a timely basis. The applicant must ensure that a child's assessment and Treatment Plan is completed in a timely manner consistent with certification expectations, namely:

1) After receiving a written referral or a request for HBTS, the provider-agency must make telephone contact with families within seven calendar days to schedule an intake appointment.

2) If appropriate for HBTS, an intake appointment must take place within three weeks of the telephone contact.

3) Treatment Plans must be developed and provided for review and authorization either to a CEDARR Family Center or DHS within 4 weeks of a completed intake appointment.

4) When developing a Treatment Plan for a CEDARR Family Center or DHS, the provider-agency must be able to fully staff a proposed level of treatment intensity within four weeks of commencing treatment. The Treatment Plan must reflect the ability of the provider-agency to staff a child's plan.

6.5.1.5 Treatment Plan Modification and Renewals

The applicant must describe its procedures for Treatment Plan monitoring and modification of treatment throughout a course of care. Resources (i.e., staff and staff responsibilities) and processes (e.g., clinical supervision, treatment consultation and treatment coordination) must be identified to ensure that data is collected, analyzed, and used to inform further treatment during an approved course of HBTS. It is necessary to demonstrate how data is used during clinical supervisory sessions and parent consultations to inform the delivery of care. It must also be evident that data is appropriately maintained and reviewed for determining future HBTS needs.
It is recognized that achieving treatment objectives will vary for many reasons. However, when treatment progress falls significantly below expectations for the provider or family, or there is evidence of regression during a course of HBTS, each factor associated with an unsatisfactory outcome must be specifically addressed. Changes and modifications to treatment that result from this must also be described in detail. The provider must demonstrate that this takes place throughout a course of care.

When seeking re-authorization of HBTS, it is insufficient to simply list incomplete treatment outcomes or regression as justification for HBTS. The HBTS provider must demonstrate how HBTS services can maximize the achievement of goals and improved functioning for the child and, when appropriate, the family. This means reviewing methods of intervention and ensuring that best practices are followed. The latter must also address the use of other professional services (e.g., individual or family therapy, ~~or~~ consultation with a child psychiatrist) as well as a reexamination of treatment objectives and treatment intensity when formulating requests for services.

The HBTS provider-agency must agree to provide a summary of the child's response to HBTS to the child's primary care provider and other interested parties related to the child's Treatment Plan upon written request from the parent or guardian.

6.5.2 Management of Clinical Services

The applicant must demonstrate a sound organizational approach to ensuring the provision of effective, timely and high quality services. Certified providers will demonstrate that the care process is systemically organized and grounded in sound clinical principles. Refer to section 7.4 for additional requirements. In this section, the applicant will describe its clinical and administrative organization and management model for Home-Based Therapeutic Services.

It is incumbent upon an applicant choosing to offer Home-Based Therapeutic Services to provide agency credentials, as represented by DOH, DCYF and/or MHRH licensure, and identify any agency accreditation provided by national governing bodies (e.g., CARF, CASFC, COA, JCAHO, ORS, etc.). Therefore, the applicant must attach copies of appropriate licensure(s) and agency accreditation(s). Appendix 13 provides a list of common accreditation organizations.

The following areas must be addressed:

6.5.2.1 Clinical Roles and Scope of Practice

The work of the HBTS team must be systematically organized with clear delineation of the staff roles, reporting relationships and supervision. Detailed job descriptions must be provided for each member of the team. Protocols will include clear delineation of the role and scope of practice of each position within the HBTS treatment team in such areas as:

1. Supervision and scope of practice.
2. The ways in which clinical supervision is effected, ratio of supervisor time to treatment team staff time.
3. Staff evaluation.
4. Treatment Plan design, monitoring, evaluation and Treatment Plan modification.
5. Coordination with family.
6. Coordination with CEDARR Family Center and communication with other service providers as appropriate.

The organizational chart must identify the specific individuals who fill identified positions and list credentials. Personnel must meet all applicable State licensure and certification requirements. Position job descriptions must be provided and address such areas as:

1. Reporting relationship.
2. Functional tasks and performance expectations.
3. Required skills, training, and experience.
4. Licensure qualifications

6.5.2.1.1 Agency Orientation and Training

All staff shall be provided with a general orientation to the provider-agency with respect to its mission, policies and procedures, administrative structure, training, and other relevant information. The provider-agency must have policies and programs for orientation, training of

new staff, and for continuing education and professional development that fully meet the Certification Standards. Staff is required to participate in these activities, as specified by the individual's position and job description.

Personnel files shall contain documentation of the training programs staff has completed. Provider-agencies must have a written program for in-service training and orientation of all new employees. Provider-agencies shall annually determine staff training needs and develop a written plan and schedule of staff training.

6.5.2.1.2 Preparation of Home-Based Staff

The provider-agency shall delineate the requirements used to ensure that all clinical staff and home-based workers are fully qualified to implement all aspects of a Treatment Plan before engaging in the delivery of care to a family. As a condition of employment and on a case-by-case basis, home-based staff shall have basic knowledge and skills. The provider-agency shall demonstrate its required basic training for all home based workers. It is recommended that basic training for all home-based workers shall include, but not be limited to the following:

Clinical Training
Child Development
Behavior Modification
Family Dynamics
Crisis Intervention
Substance Abuse
Psychiatric/Medical Disorders
Developmental Disabilities

Medical Training
Emergency Measures
Medications
Appropriate Restraint Techniques

Provider-agencies shall have an ongoing training that all staff must attend. Some training topics under HBTS Specifics (see below) shall occur prior to a home-based Specialized Treatment worker and home-based Treatment Support worker delivering services to a child.

HBTS Specifics
Client rights
Ethics and confidentiality
Reporting procedures and documentation requirements
Overview of the clinical record and Treatment Plan

6.5.2.2 Supervision

Clinical Supervision of home-based staff must occur throughout a period of authorized treatment. Policies and procedures must be in place to ensure the reliability and availability of supervision by qualified personnel (See Section 5.4.1). This means:

1. HBTS staff must have appropriate credentials and meet qualifying standards to provide supervision.

2. Written policies and procedures that demonstrate a clear supervisory structure that guides the delivery and implementation of treatment, supervision of home-based workers (i.e., specialized treatment and treatment support), and management of clinical services, including assessment of progress and modifications to Treatment Plan.

3. Defining the ratio of supervisor's time to treatment team staff, showing the ways in which clinical supervision is provided.

4. Protocols identifying team meetings, team participants, and process for periodic assessment and treatment plan revisions as appropriate.

6.5.2.2.1 Applied Behavior Analytic (ABA) Services

The treatment of children with Autism and related disorders with ABA discrete trial interventions is highly involved and requires specific competencies. The use of ABA methods for individuals with Autism and their families has received considerable multidisciplinary study and is regarded as an evidence-based practice. While ABA is not the only treatment approach for children with Autism, it is being used by provider-agencies. Provider-agencies vary according to the degree to which ABA is employed, as well as the level of sophistication and training of staff providing clinical supervision to home-based specialized treatment staff.

Provider-agencies with DHS recognized ABA programs for HBTS, may request additional hours to support planning, directing and supervising effective ABA interventions when Treatment Plan requests exceed DHS maximum limits.

For provider-agencies who want to qualify for the specialized practices applicable to ABA recognized providers, the provider-agency must identify their clinical framework as being an ABA program. Additionally, DHS requires these provider-agencies to identify staff and their qualifications with respect to:

Formal Training of a Clinical Supervisor, commonly referred to as a "Behavior Analyst" must meet the following criteria:

a) Master's or doctorate in behavior analysis, or in psychology, special education, or another human service discipline with an emphasis in behavior analysis and,

b) Coursework in principles of learning, principles of behavior, or basic behavior analysis; experimental analysis of behavior, behavior assessment or methods of direct observation of behavior; applied behavior analysis; single-subject research designs; and legal and ethical issues, and

c) Supervised practicum, internship, fellowship, or employment experiences in ABA.

To further avoid any confusion to families and provider-agencies, DHS recognizes the term "Behavior Analyst" as applying only to those individuals who can demonstrate satisfactory

compliance with the above-mentioned requirements. Provider-agencies are directed to Appendix 14 for additional information regarding the formal credentialing of professional behavior analysts.

6.5.2.3 Staffing and Staff Qualifications

It is the responsibility of a provider-agency to conform to DHS requirements regarding staff credentials, training, personnel management, and practice guidelines. Staff requirements differ with respect to the role and functions associated with providing HBTS. The provider-agency shall demonstrate that it meets the specific staffing requirements for the home-based worker, Clinical Supervisor, Treatment Consultant, and Treatment Coordinator. The applicant must therefore give written assurances that these standards will be provided and maintained as a requirement for receiving and maintaining certification.

With respect to continuing education, the provider-agency shall have policies and procedures in place for all employees consistent with DHS certification and licensure requirements. This requires that:

1) Licensed health care professionals providing clinical supervision and treatment consultation conform to DOH continuing education requirements according to respective disciplines. Therefore, the applicant is directed to consult with Department of Health guidelines for licensure of individual health care professionals.

2) For non-licensed clinical staff, and only for those considered under the variance of licensure condition, 10 hours per year of continuing education are required from accredited programs with national or regional certifying authority. Individual staff certification to provide clinical supervision and treatment consultation must be renewed on an annual basis. Therefore, the agency must demonstrate that it can monitor and enforce this standard for employees who are subject to a variance from licensure. Refer to section 2.8 for additional information relating to licensure and variance from licensure.

A Background Criminal Investigation (BCI) and Child Abuse Neglect Tracking System (CANTS) by DCYF are required of all potential employees. The provider-agency has policies in place to ensure that these screenings take place. In addition, the following requirements must be met unless otherwise approved by DHS for HBTS employees.

Agencies shall have policies and protocols that offer families clear information as to the qualifications of all staff assigned to work with their child, as well as their right to request substitutes.

6.5.2.3.1 <u>A Home-Based Specialized Treatment Worker Must</u>:

1) Be at least 19 years of age; have a high-school degree or equivalent, and two years of supervised experience working with children with special health care needs, or

2) Have an Associate's degree in human services (i.e., psychology, counseling, child development, education, nursing, etc), or

3) Be currently enrolled in not less than six (6) semester hours of relevant undergraduate coursework at an accredited college or university, or

4) Demonstrate competency to work with children with special health care needs (as outlined in 6.5.2.1.2) as evidenced by active participation in an agency-specific formal training program, approved by DHS, and successful completion of objective testing within twelve (12) months of hire, and

5) Have successfully passed a BCI and CANTs.

6.5.2.3.2 A Home-Based Treatment Support Worker Must:

1) Be at least 19 years of age; have a high-school degree or equivalent, and one year of supervised experience working with children, or

2) Have an Associates degree in human services (i.e., psychology, counseling, child development, education, nursing, etc), and

3) Have successfully passed a BCI, and CANTs.

4) Demonstrate competency to work with children with special health care needs as evidenced by provider-agency's skills validation requirement.

6.5.2.3.3 A Clinical Supervisor Must:

Be a Rhode Island licensed health care professional eligible to provide Clinical Supervision. Licensure must be in one of the following: licensed independent clinical social worker, marriage and family therapist, mental health counselor, registered nurse with a Masters degree, or psychologist.

1) Have successfully passed a BCI, and CANTs

2) Unlicensed individuals currently providing services must have DHS approval to render clinical supervision (See: Section 2.8 and Appendix 4).

6.5.2.3.4 A Treatment Consultant Must:

Be a Rhode Island licensed health care professional eligible to provide Treatment Consultation. This may include one of the following categories: licensed independent clinical social worker, marriage and family therapist, mental health counselor, registered nurse with a Masters degree, psychologist, Occupational Therapist, Physical Therapist or Speech and Language Pathologist.

1) Have successfully passed a BCI and CANTs.

2) Unlicensed individuals currently providing services must have DHS approval to render Treatment Consultation (See: Section 2.7.2 and Appendix 4).

3) The hiring of OT, PT and SLP therapists employed by a Local Education Authority (LEA) may be subject to DOE and/or LEA regulations that could limit or prohibit their participation as Treatment Consultants for HBTS. Independently licensed professionals may not be prohibited from providing treatment consultation. It is the responsibility of the provider-agency to confirm if a conflict of interest exists.

6.5.2.3.5 A Treatment Coordinator Must:

1) Possess a minimum of a Bachelor's degree.

2) Have successfully passed BCI and CANTs.

6.6 Timeliness of Service, Other Access Standards

Fully certified providers will be in compliance with the certification standards and meet performance standards for the timeliness of services provided. There are performance standards for timeliness of services provided to newly referred clients, those individuals who are referred to the provider agency for services through a written treatment referral from a CEDARR Family Center and who have received no HBTS treatment provided by the provider agency, as well as performance standards for renewing clients, those individuals who have received HBTS treatment from the provider agency, are determined to require HBTS treatment beyond the authorization period, and will have another treatment plan submitted for reauthorization.

6.6.1 Timeliness Standards for NEW Referrals

The HBTS Provider Agency must meet the following timeliness performance standards.

Intake Appointment

The performance standard is an HBTS provider agency must conduct an intake appointment for at least 80% of those requesting an appointment within 3 weeks of treatment referral. Conducting less than 80% of intake appointments within this prescribed timeframe may result in provisional certification status.

Treatment Plan Submission

The performance standard is that an HBTS provider agency must submit at least 80% of new treatment plans for those of whom home based therapeutic services are appropriate to CEDARR Family Centers for approval within 4 weeks of intake appointment. Submitting less than 80% of new treatment plans within this prescribed timeframe may result in provisional certification status.

Initiation of Direct Services

The performance standard is an HBTS provider agency must initiate direct services for at least 80% of new clients within 4 weeks of treatment plan authorization. Initiating direct services for less than 80% of new clients within this prescribed timeframe may result in provisional certification status.

6.6.2 Timeliness Standards for RENEWING Cases

The performance standard is an HBTS provider must submit for reauthorization all (100%) treatment plans requiring renewal at least 30 days prior to expiration. Submitting less than 100% of plans for reauthorization within the prescribed timeframe may result in provisional certification status.

6.6.3 Timeliness Standards for Treatment Plan Clinical Review Process

Provider agency cooperation is required throughout the CEDARR or DHS clinical review of the proposed treatment plan. Should a clinical reviewer require clarification or additional information, the HBTS provider-agency is required to respond in writing to the reviewer within 9 calendar days.

The performance standard is that additional information requested by DHS or CEDARR Family Centers in the process of treatment plan review and reauthorization will be provided within 9 calendar days for all (100%) treatment plans for which questions arise throughout the reauthorization process. Replying to less than 100% of requests for information during the reauthorization review process within the prescribed timeframe may result in Provisional Certification status.

6.6.4 Hours of Service

HBTS must be available to families on a continual basis throughout a period of authorized treatment. The applicant shall define its administrative hours of operation, and direct service hours, which can include day, evening, and weekend coverage. Families must be informed of hours of operation for their child's Treatment Plan. Applications must include hours of operation, and procedure for accessing administrative or clinical staff.

6.6.4.1 Continuity of Care

It is the responsibility of the HBTS provider-agency to address in the application continuity of care to minimize disruptions in treatment (i.e., holidays, staff vacations, sick time, etc.). The provider-agency must demonstrate its process and procedures for maintaining continuity of care and inform parents of this responsibility. With respect to multiple home-based workers providing treatment, whether Specialized Treatment or Treatment Support, the provider-agency shall limit the number of workers assigned to a given case to ensure continuity and consistency in treatment.

6.6.5 Measures of Parent Satisfaction

Annual parent satisfaction surveys must be conducted. When multiple children within a family are receiving services, one survey is needed for each child receiving services within each family.

The format and content of the measurement tool is the responsibility of the provider agency. Areas of interest to DHS include, but are not limited to;

a) Sensitivity to family centeredness and cultural competencies,

b) Availability of Clinical Supervisor, Treatment Consultant and/or Treatment Coordinator,

c) Progress made during treatment (e.g., participation in community and quality of life outcomes),

d) Communication with family and others (e.g., CEDARR, medical professionals, school personnel),

e) Staff availability, promptness and actual delivery of authorized hours,

f) Professionalism of staff and services (i.e., treatment coordination, clinical supervision, and treatment consultation, accounting of complaints, compliments, and grievances).

It is recommended that surveys include both quantitative and qualitative feedback from parents. Survey results will be analyzed, trended and reported to DHS. Further clarification regarding content and/or reporting will be provided by DHS once the certification process has been completed.

6.7 Service Monitoring and Reporting

The HBTS Provider Agency must comply with the following service monitoring and reporting requirements. See Appendix 17 for additional information regarding reporting requirements.

6.7.1 Quarterly Reports

Provider agencies will be expected to report required data for each calendar quarter on the last business day of the month following the end of each calendar quarter (i.e., on April 30, 2003, provider-agencies will report data regarding clients newly referred and requiring reauthorization during the period of January 1 – March 31, 2003). The first Quarterly Report is due following the completion of the second calendar quarter following DHS certification of the provider agency.

Provider Agencies are required to submit the following reports on a quarterly basis:

Report 1 – Provision of authorized direct service hours

The purpose of this report is to monitor the percentage of authorized direct service hours that are provided to families.

Report 2 – Timeliness of intake appointments for new referrals

The purpose of this report is to monitor the percentage of initial intake appointments that occur within 3 weeks of a written treatment referral from a CEDARR Family Center.

Report 3 – Timeliness of new treatment plan submissions

The purpose of this report is to monitor the percentage of treatment plans that are submitted to a CEDARR Family Center for authorization within 4 weeks of an initial intake appointment.

Report 4 – Timeliness of direct service initiation

The purpose of this report is to monitor the percentage of families for which direct services are initiated within 3 weeks of treatment plan authorization.

Report 5 – Timeliness of renewing treatment plan submissions

The purpose of this report is to monitor the percentage of expiring treatment plans which are submitted for reauthorization at least 30 days prior to the expiration date.

6.7.2 Annual Reports

Provider Agencies will also be required to provide reports on an annual basis. Annual reports are to be submitted on the first business day on or after the close of the state fiscal year, July 1 – June 30 (i.e., June 30, 2003.) The first annual report is due at the close of the fiscal year in which DHS certifies the provider agency.

Provider-agencies are required to submit the following reports and documents on an annual basis:

- Licensure status report for unlicensed consulting/supervising staff
- Documentation of trainings conducted and attended by direct service workers and clinical supervisors
- Written documents provided to families regarding their rights and responsibilities and documents demonstrating family-centeredness
- Summary of family satisfaction survey methods and results

- Minutes and other materials of the Quality Assurance Committee
- Summary report on all complaints received and logs of timeliness of complaint resolution
- For all non-licensed clinical supervisors and treatment consultations, documentation of continuing education units.

6.7.3 Additional Service Monitoring and Reporting

DHS may also request additional reports, documentation, and site visits, as necessary to monitor compliance with these Certification Standards and services provided by the provider-agency.

6.8 Record Keeping Requirements

The provider-agency must describe its policies and procedures for record keeping. Systematic recording of HBTS hours provided on a weekly basis with family verification is required. For the home-based worker, time sheets documenting the specific hours of service provided per shift must be co-signed daily by the family receiving services. Services billed shall correspond to the approved hours requested in a Treatment Plan and be supported by written documentation.

Appendix 15 (Documentation Guidelines) provides further detail for compliance with Medicaid regulations. The provider-agency must provide long-term storage of clinical records in accordance with Medicaid regulations. Additional record keeping requirements are described in Section 7.

6.9 Emergency Coverage

Whenever a home-based worker is working with a child during shifts, there shall be back-up staff (e.g., Clinical Supervisor or Treatment Consultant) immediately available to provide consultation and/or direction to staff and/or families should a crisis situation develop. This requires a response to a telephone call or page within 15 minutes and on-site assistance, as necessary, within 60 minutes of the request call. An emergency or crisis is characterized by sudden onset, rapid deterioration of cognition, judgment, or behavior, is time limited in intensity and duration, and poses serious risk of harm to the individual or others.

HBTS provider-agencies shall describe its processes for developing an emergency plan. An emergency plan must be included with the HBTS Treatment Plan. This must be periodically reviewed/revised with a child's parents or guardian. During non-shift times, parents must be aware of specific steps to take in the event of a crisis (e.g., calling the police or seeking emergency evaluation for medical treatment). This plan must be developed in coordination with the CEDARR Family Center.

7.0 QUALIFIEDENTITY

A certified provider must be able to demonstrate that it complies with core State requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance improvement and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

Applicants for certification are not required to systematically address in detail each of these areas in their certification applications. Rather, these are set forth as fundamental requirements for certified entities. In many areas applicants will be asked to provide assurances that their agency systematically addresses each of the standards identified. In certain areas, more specific description regarding the manner in which the agency meets the standard is required. The Application Guide provides guidance as to how the application should be structured and the areas, which need to be addressed.

In not requiring applicants to explicitly address the elements in Section 7, the State is seeking to simplify the effort needed to develop an application; these certification requirements remain in place. The State reserves the right to review certified entities for compliance with these certification requirements.

7.1 Incorporation and Accountable Entity

The applicant for certification as a Home Based Therapeutic Services provider-agency must be legally incorporated. The certified entity shall serve as the accountable entity responsible for meeting all of the terms and conditions for providing HBTS. Applicants must clearly present the overall structure by which services, requirements and programmatic goals will be met. The corporate structure of the entity must be clearly delineated.

7.1.1 Partnership or Collaboration

Satisfactory performance as a certified HBTS provider-agency calls for significant organizational capability. In some cases this capability may be present within a single organization and application for certification will be made based on the strengths of that single organization. In other cases the application may represent the joint effort of several parties, which have the combined capabilities to meet the certification requirements. This could come, for example, through a joint venture, a formal partnership or an integrated series of executed contractual arrangements. Regardless of form, a single legal entity will be certified with overall responsibility for performance.

The certified HBTS provider-agency is to be the single billing agent for all HBTS.

7.2 Governance and Mission

The governance of the entity must be clearly delineated. Composition of the Board of Directors and any conditions for membership must be clear. The overall performance of an organization flows from the philosophy and oversight of the leadership. Leadership and stakeholders "build" the mission, vision and goals; this in turn shapes the business behavior and is reflected in the tone that leadership sets for the operation of the organization. The leadership strives to recruit members who reflect the cultures and ethnic backgrounds of clients, and to provide a mix of competencies that address organizational needs. Specific standards regarding governance and mission are as follows;

1) The agency has a clearly stated mission and publicly stated values and goals.

2) The agency is operated/overseen by some type of legally or officially established governing body, with a set of governing documents or by laws. This governing body has full authority and responsibility for the operation of the organization.

3) The governing body is self-perpetuating and has a recruitment and periodic replacement process for members to assure continuity and accountability.

4) The governing body hires, supervises, and collaborates with a chief executive officer or director. Together the executive and governing bodies provide organizational leadership.

5) The governing body has final accountability for all programs. Through a collaborative relationship with the executive and the management team, the governing body is responsible for developing the program goals and mission and ensuring compliance with legal and regulatory requirements.

7.3 Well Integrated and Organized Management and Operating Structure

The HBTS provider-agency will be able to function in an efficient and effective manner, assuring consistency and quality in performance and responsiveness to the needs of families. The applicant shall provide clear identification of who is accountable for the performance of HBTS. This includes administration, clinical program quality, and management of service delivery and overall financial management.

7.3.1 Administration

Specific standards regarding administration are as follows:

1) The Executive, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.

2) A current chart of organization, which clearly defines lines of authority within the organization, must be maintained and provided as part of the certification application.

3) The management of the organization is involved in the planning process for performance improvement and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement plan.

4) There is a written corporate compliance plan in place that is adopted by the governing body.

7.3.2 Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to clients. Fiscal management is conducted in a way that supports the organization's mission, values, and goals and objectives in accordance with responsible business practices and regulatory requirements. Financial management requires a set of sophisticated financial planning and management capabilities if the organization is to remain viable. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes.

Specific standards regarding financial systems are as follows:

1) Financial Management is provided by a Chief Financial Officer, Fiscal Director, or Manager with demonstrated experience and expertise in managing the finances of a human services organization with third party reimbursement. In larger organizations (e.g. with revenues in excess of $1 million) this might be an MBA with demonstrated finance experience or a CPA; in smaller organizations a comptroller with a degree in accounting might be sufficient. This individual must possess expertise in financial and client/patient accounting, financial planning and management.

2) The organization's financial practices are consistent with the most up to date accounting methods and comply with all regulatory requirements.

3) The organization's financial planning process includes annual budgeting, revenue projections, regular utilization and revenue/expense reports, billing audits, annual financial audits by an independent CPA, and planning to ensure financial solvency.

4) The organization has written policies and procedures that guide the financial management activities (including written policies for and procedures for expenditures, billing, cash control; general ledger, billing system; registration/intake system; payroll system; accounts payable; charge and encounter reporting system and accounting administration).

5) The organization has evidence of internal fiscal control activities, including, but not limited to: cash-flow analysis, review of billing and coding activities.

6) The system must track utilization of service units separately for each individual client and aggregate this information by payor, performing provider and diagnosis/problem.

7) The organization has a billing office/function that bills for services rendered and collects fees for service and reimbursement.

8) The organization assesses potential and actual risks, identifies exposures, and responds to these with preventive measures.

9) The organization carries appropriate general liability insurance, and ensures that appropriate professional liability policies are maintained for program personnel.

10) Where the organization contracts with outside entities and/or providers, policies and procedures mandate contract language to detail the entity's or provider's accountability to the Governing Body and its' By-laws.

11) The organization has systems that facilitate timely and accurate billing of fee-for-service, capitated, and case-rated insurance plans, clients and other funding sources. Once bills are forwarded to payors, the system properly manages payments, follow-up billing, collection efforts and write-offs.

12) The organization has a written credit and collections manual with policies and procedures that describes the rules governing client and third-party billing. Specifically, the organization has in place and adheres to policies and procedures ensuring compliance with Medicaid regulations pertaining to coordination of benefits and third party liability. Medicaid by statue and regulation is secondary payer to all other insurance coverage.

13) Clinical, billing and reception/intake staff receives ongoing training and updates regarding new and changed billing and collection rules and regulations.

7.4 Human Resources, Staffing

Human Resource activities within the organization are conducted to ensure that proper staffing for optimum service delivery to clients occurs through hiring, training, and oversight of staff activities. The activities are organized to serve the governing principles of the organization and compliance with these Certification Standards. The organization provides clear information to employees about job requirements and performance expectations, and supports continuing education, both internal and external, that is relevant to the job requirements of the individual. In addition, all staff receive training about major new organizational initiatives and about key issues that may affect the organization overall.

Specific standards regarding Human Resources and Staffing are as follows:

1) The organization's personnel practices contribute to the effective performance of staff by hiring sufficient and qualified individuals who are culturally and linguistically competent to perform clearly defined jobs.

2) Employee personnel records are kept that contain a checklist tickler system to track appropriate training, credentialing and other activities. A copy of each employee's active license will be kept on file.

3) The provider-agency must perform annual written performance appraisals of staff based on input from families and supervisors. These must be available in the personnel files for review by DHS upon request.

4) Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.

5) Staff is hired that match the requirements set forth in both the appropriate job description and in the policies and procedures.

6) Each employee's record contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. Supervisory job descriptions establish expectations for both contributing to the organization's goal attainment and for communicating the goals and values of the organization. All job descriptions include standards of expected performance.

7) The organization provides a clear supervisory structure that includes plainly delineated spans of control and caseloads as appropriate. The roles of team members are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching to develop their capacities to function as managers and experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision. This includes:

    a) Protocols for communication and coordination with all interested parties (e.g., special education, primary care physician, or other specialists).

    b) Clear procedures for addressing unmet licensure requirements will be stated. Credentialing records will be maintained annually to document compliance.

8) Credentials of staff established by the management team and approved by the Governing Body are contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, as appropriate, and records maintained in the employee's record.

9) A record of primary source verification is maintained in the individual employee record. This includes, at a minimum, verification of licensure, review of insurance coverage/

liability claims history, verification of board certification for physicians, verification of education and training required by law, and professional references and performance evaluations about applicant's ability to perform requested duties. The individual employee record for behavioral health practitioners should also contain a signed statement from the practitioner that addresses if any Medicare or Medicaid sanctions have been imposed in the most recent three-year period.

10) Staff has appropriate credentials and meets qualifying standards of the organization. These are updated and checked regularly.

11) The organization provides training and training opportunities for all levels of staff.

12) Staff is required to participate in training activities on an ongoing basis, as specified by the organization and position and job descriptions.

7.5 Quality Assurance/Performance Improvement

The organization is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement plan). The organization ensures that information is collected and used to improve the **overall** quality of service and performance of the program. The Quality Assurance/Performance Improvement (QA/PI) program that the organization develops strives to: improve the systems related to the delivery of service to the clients; include the preferences of clients in the provision of services; and measure the process and outcomes of the program services. The QA/PI program is an ongoing process of planning, monitoring, evaluating, and improving the system in order to improve the outcomes of service provided to clients.

Standards regarding Quality Assurance/Performance Improvement are as follows:

1) The organization has a Quality Assurance/Performance Improvement program that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records review and operational/systems improvement. Written records are maintained for PI program activities.

2) The PI program contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.

3) Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes.

7.6 Information Management, Record Keeping

The organization must use data to affect the performance, stability, and quality of the services it provides to clients, in its governance, and other systems and processes.

Standards regarding information management and record keeping are as follows:

1) The organization obtains, manages, and uses information to enhance and improve its performance. Information it maintains is timely, accurate, and easily accessible, whether maintained in electronic or other format. Evidence exists that information gathered and maintained is used in decision-making for the organization.

2) The organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.

3) The organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements when such standards are promulgated and effective.

4) The information management plan specifies standard forms and types of data collected for client intake, admission, assessment, referral, services, and discharge.

5) The information management plan has an incident reporting and client grievance-reporting component.

6) Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.

    a) The organization maintains signed releases for sharing of clinical information.

    b) Where necessary, signed affiliation agreements exist.

    c) Reports are available on an appropriate schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, case managers, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress.

    d) Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis.

7) The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure.

    a) The organization has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.

b) Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.

8) Client information is accessible and is maintained in a consistent and timely manner, with enough information to support the consumer's needs or diagnosis, to justify services delivered, and to document a course of treatment and service outcomes.

   a) Every client will have a record that contains: an initial assessment, the detailed assessment of client assets and needs, client goals care/Treatment Plan, documentation of care/services provided, documentation of change in client's status, and where necessary, discharge summary.

   b) All records must include evidence of informed consent, where required.

9) The client record documents treatments/interventions provided and results from the treatments/interventions. All entries into the client records are dated and authenticated, and follow established policies and procedures.

   a) Changes in client's condition or lack of change following service provision are recorded in the client record at the time of service provision and signed by the service provider.

   b) Achievement of a client objective or milestone toward an objective is noted in the client record. Achievement of an objective or milestone results in a revised assessment.

   c) Lack of progress in achieving a client objective or milestone toward objective results in a reassessment of the client.

10) The client record will be the basis for billing. All service billings must be substantiated in the client record. Additional clarification regarding Medicaid and DHS requirements is included in Appendix 15.

7.7 Health and Safety, Risk Management

The organization supports an environment that promotes optimal safety and reduces un-necessary risk for clients, family members and staff. The home-based nature of HBTS calls for specific policies and procedures to assure that services are provided in a safe and effective manner for both the child and the staff.

Standards regarding Health, Safety, and Risk Management are as follows:

1) The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement program committee and the Governing Body.

2) The organization will have protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.

3) Health and safety policies and procedures are clearly communicated to agency staff, visitors, and clients.

4) Programs will have an effective incident review process.

7.7.1 Transportation

In the course of provision of services the provider-agency may want to provide transportation if clinically relevant. The State is approving only the service provision and accepts no liability or responsibility for transportation. Inclusion of transportation as part a Treatment Plan is only appropriate if it clearly relates to facilitating the accomplishment of defined and previously approved treatment objectives. Transportation can only relate to the child receiving HBTS and is not to be included in a treatment plan for solely convenience.

The provider-agency must demonstrate that it has procedures in place to protect the safety of child being transported. This means addressing certain minimum criteria for all staff and vehicles engaged in transportation:

1) Current and appropriate vehicle insurance that allows for transporting children.

2) Current vehicle registration and valid State inspection.

3) The driver's history must be free of accidents for the past year, with no history of DWI.

4) Parents have signed a waiver for each driver releasing DHS of any liability and responsibility for anything that occurs as a result of transportation activities.

5) DHS will not approve 2:1 coverage during transportation except under extremely unusual situations subject to prior approval from DHS or CEDARR.

APPENDIX 1: DEFINITION OF MEDICAL NECESSITY

As defined and applied to all State Medicaid programs (See: RI DHS Medical Assistance Program, 300-40-3, September 1997), Medical Necessity refers to medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition. It includes services necessary to prevent a decremental change in either medical or mental health status. Services must be provided in the most cost effective, efficient and appropriate manner. Services are not to be provided solely for the convenience of the beneficiary or service provider.

The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity (See RI DHS Medical Assistance Program, 300-40-4, September, 1997).

APPENDIX 2: CEDARR AUTHORIZATION PROCESS FOR HBTS

Families may seek HBTS through referral and authorization by a CEDARR Family Center. Services provided by a CEDARR Family Center are intended to benefit families by helping them obtain information and the appropriate services for their child. The CEDARR Family Center helps by arranging specialty clinical evaluation, if required, developing a Family Care Plan, identifying resources, and providing coordination of care.

The CEDARR Family Center makes recommendations, and parents are given information about professionals, resources, and different treatments. The following process takes place:

1) If HBTS is recommended, families are given several HBTS Direct Service Providers to choose from and referrals are sent out. At this time parents are informed about the availability of HBTS prior to referrals being made.

2) The HBTS Direct Service Provider then submits a Treatment Plan to the CEDARR Family Center for a clinical review and authorization.

3) The specifics are authorization are as follows:

    a) HBTS provider-agencies must develop and submit written Treatment Plans to the CEDARR Family Center no later than four weeks prior to beginning treatment services. Retroactive requests and/or unauthorized periods of providing services are not allowed.

    b) A Treatment Plan must include clearly defined treatment objectives with measurable outcomes. Treatment must conform to professionally recognized and established clinical practice guidelines. A CEDARR Family Center has the right to request published research regarding clinical efficacy. Hours of treatment and a weekly schedule must be stated. Individuals providing clinical supervision, treatment consultation, and treatment coordination must be identified along with their hours.

    c) Each Treatment Plan receives a thorough clinical review. Treatment Plans are reviewed within thirty (30) days of their receipt at the CEDARR Family Center.

    d) The clinical review process frequently involves written and verbal communication between provider-agencies and reviewers in order to facilitate a thorough understanding regarding a request for services. As a result, recommendations to modify an initial Treatment Plan may be made in terms of goals, treatment intensity, or indirect services. Changes in treatment intensity require parental consent.

    e) Based on clinical review, actions are taken by the CEDARR Family Center for authorization or denial of service. Written notification is sent directly to provider-agencies by the CEDARR Family Center and to the parents.

f) Provider-agency cooperation is sought to resolve treatment questions prior to issuing a denial of authorization. The provider-agency must then review proposed treatment changes with a child's parents/guardians and obtains their consent. Once a revised plan has been obtained, services may then be authorized with written notification to the provider-agency and family.

g) If a Treatment Plan is unsatisfactory, the provider-agency has nine (9) days to respond to clinical reviewer's questions or concerns. Written responses are required of provider-agencies. Untimely or unsatisfactory responses may result in changes to a Treatment Plan including reductions in treatment intensity, duration of treatment, or denial of a Treatment Plan.

h) If the concerns raised during a clinical review of a Treatment Plan are not successfully resolved, clinical reviewers at DHS will conduct a second independent review of the Treatment Plan. The review decision is sent to the CEDARR Family Center who then forwards this decision to the provider-agency.

i) For families receiving HBTS, there is a right to appeal any denial of HBTS or modification of treatment intensity.

j) If there are substantial changes in a child's level of functioning (e.g., inpatient hospitalization or regression) that could require service changes during an approved period of care, it is the responsibility of the provider-agency to inform the CEDARR Family Center and receive approval to amend the Treatment Plan. These requests are then subject to the same review process as for initial requests.

k) Provider-agencies have the responsibility to submit requests for reauthorizations of care thirty (30) days -month prior to the expiration of an existing Treatment Plan for review.

4) The CEDARR Family Center is responsible to provide the following functions: clinical review of an HBTS Treatment Plan, authorization, oversight, and collaboration with the HBTS provider-agency.

5) The HBTS Direct Service Provider is responsible to the CEDARR Family Center for all utilization and authorization of care. In order to render HBTS as a direct service, the provider-agency must be certified as a CEDARR Direct Service Provider.

APPENDIX 3: DHS AUTHORIZATION PROCESS FOR HBTS

For existing provider-agencies of HBTS, DHS has required the following steps in order to secure authorization and reimbursement for services. They are:

1) HBTS provider-agencies must develop and submit written Treatment Plans to DHS no later than thirty (30) days prior to beginning treatment services. Retroactive requests and/or unauthorized periods of providing services are not allowed.

2) A Treatment Plan must include clearly defined treatment objectives with measurable outcomes. Treatment must conform to professionally recognized psychotherapeutic approaches and established clinical practice guidelines. DHS has the right to request published research regarding clinical efficacy. Hours of treatment and a weekly schedule must be stated. Individuals providing clinical supervision, treatment consultation, and treatment coordination must be identified along with their hours.

3) Each Treatment Plan receives a thorough clinical review. Treatment Plans are reviewed within thirty (30) days of their receipt at DHS. Parents are notified of a plan's receipt.

4) The DHS clinical review process frequently involves written and verbal communication between provider-agencies and reviewers in order to facilitate a thorough understanding regarding a request for services. As a result, recommendations to modify an initial Treatment Plan may be made in terms of goals, treatment intensity, or indirect services. Changes in treatment intensity require parental consent.

5) Based on clinical review, actions are taken by DHS for authorization or denial of service. Written notification by DHS is sent directly to provider-agencies and parents.

6) Provider-agency cooperation is sought to resolve treatment questions prior to issuing a denial of authorization. The provider-agency must then review proposed treatment changes with a child's parents/guardians and obtains their consent. Once a revised plan has been obtained, services may then be authorized with written notification to the provider-agency and family.

7) If a Treatment Plan is unsatisfactory, the provider-agency has nine (9) days to respond to clinical reviewer's questions or concerns. Written responses are required of provider-agencies. Untimely or unsatisfactory responses may result in changes to a Treatment Plan including reductions in treatment intensity, duration of treatment, or denial of a Treatment Plan.

8) For families receiving HBTS, there is a right to appeal any denial of HBTS or modification of treatment intensity regarding reauthorization.

9) If there are substantial changes in a child's level of functioning (e.g., inpatient hospitalization or regression) that could require service changes during an approved period of care, it is the responsibility of the provider-agency to inform DHS and receive approval to amend the Treatment Plan. These requests are then subject to the same review process as for initial requests.

10) Provider-agencies have the responsibility to submit requests for reauthorizations of care thirty days prior to the expiration of an existing Treatment Plan for review.

APPENDIX 4: LICENSURE AND PRACTICE STANDARD

1. Core Requirements for HBTS Certification

1.1 Licensure

These Certification Standards require that individuals engaged in providing Clinical Supervision or Treatment Consultation as part of HBTS hold a currently valid license from the Rhode Island Department of Health (DOH). DOH and the Department of Mental Health, Retardation and Hospitals Regulations (MHRH) require that professionals be licensed for their respective specialties (i.e., mental health counselor, marriage and family therapist, nurse, psychiatrist, psychologist, or social worker). For social workers, an LICSW is required by DHS for engaging in the practice of Clinical Supervision and Treatment Consultation for HBTS.

DOH stipulates that licensure is required for health care professionals if:

1) You represent yourself in name, title, or abbreviation to the public as a psychologist, clinical social worker, marriage and family therapist, or mental health counselor; or

2) You engage in providing diagnosis, assessment, treatment planning, and treatment to the public.

Relevant DOH policies are:

- Clinical Social Worker: R5-39.1 CSW/ICSW
- Mental Health Counselor and Marriage and Family Therapist: R5-63.2 MHC/MFT
- Psychologist: RS-44-PSY
- Occupational Therapist: R5-40.1-OCC
- Physical Therapist: R5-40-PT/PTA
- Speech Pathologists and Audiologists: R5-48-SPA
- Physician: R5-37-MD/DO
- Nurse: R5-34-NUR/ED

Relevant MHRH policies are:

- MHRH Section 800 Program Administration, Professional Qualifications and Supervision

1.2 Competency

Licensure relates to broad areas of clinical practice and by itself does not ensure that providers have the specific and current competencies to work effectively with the special needs addressed in HBTS. In addition to licensure, DHS requires that individuals engaged in providing Clinical Supervision or Treatment Consultation in HBTS demonstrate competency to work with specific target populations. Specifically, evidence of the following is required:

1.2.1. Training:	2 years of supervision post degree while working with related target population(s); and
1.2.2. Education:	Ongoing continued professional education. Evidence of such education could include, for example, certification as a "Behavior Analyst" granted by the Autism Special Interest Group (SIG) of the Association for Behavior Analysis.
1.2.3 Continuing Education	Licensed clinicians must conform to the requirements of their respective Boards for maintaining continuing education credits. Provider-agencies are responsible for oversight and management of this requirement.

2.0 Special Provisions for Individuals Seeking Exception from Licensure

These standards require that persons providing clinical supervision and treatment consultation must be licensed by DOH. DHS recognizes that, in certain cases, unlicensed individuals have been providing these services in existing HBTS provider agencies. In order to recognize these persons and to support effective transition for agencies and for clinical staff, an exception to this requirement can be made for non-licensed persons serving in these roles with existing HBTS agencies as of August 15, 2002. Individuals granted an exception under these provisions shall be supervised by a licensed clinician or Treatment Consultant, who shall approve and bear professional responsibility for all aspects of the Treatment Plan

In order to be granted an exception, the applicant must provide a description of the individual's role and background and this must be submitted as part of the certification application material. If confirmation by the agency for inclusion within the Transitional Clinicians Group is to be considered, evidence is required that an employment relationship or a contractual relationship for performance of these roles was in place on this date.

Determinations will be established on a case-by-case basis related to the individual's level of education, acquired training, supervised experience, and work history. The individual must meet (2.1.1) basic competency requirements, or (2.1.2) exception criteria, and (2.1.3) continuing education requirements. The criteria are listed below:

2.1.1 Demonstrated Competency

Education:	Minimum of a bachelor's degree in a related field (e.g., special education, child development, psychology, or counseling)
Training:	Demonstration of in house training and professional development conferences attended over the last 3 years of current employment specific to target populations.

Supervised practice: 2 years at a minimum of 1 hour per week provided by a licensed professional with experience serving target populations.

Recommendations: 3 letters including one from a current supervisor and program director.

2.1.2 Other Exception Criteria:

a) The individual's status falls under MHRH regulations that allow for non-licensed individuals to provide clinical services when classified as a Principal Counselor or as Counselor (See: MHRH policy), as of August 15, 2002.

b) The Autism Special Interest Group (SIG) of the Association for Behavior Analysis has certified the individual, as a Behavior Analyst. This is a program of advanced education. Given this designation, the individual may employ the term "Behavior Analyst." Individuals lacking this certification should refrain from its use so as to avoid misrepresentation and confusion to the general public.

c) The Individual has a Masters degree in applied behavioral analysis.

d) Other accreditation or certification as shall be acceptable to DHS.

2.1.3. Continuing Education Requirement:

All non-licensed staff approved to provide Clinical Supervision and Treatment Consultation must receive continuing education throughout the course of employment from accredited programs with national or regional certifying authority. Ten (10) hours per year are required.

APPENDIX 5: DESCRIPTIONS OF CONDITIONS ASSOCIATED WITH TARGET POPULATION:

Diagnostic conditions for which HBTS may be appropriate can include, but are not limited to, those noted below. This is provided as a point of reference only. For many children with the conditions or diagnoses noted here, HBTS will not be the optimum service. HBTS may be effective for children with diagnoses other than those noted here. Appropriateness determination should be based on multiple factors and not diagnosis alone.

- Autistic Spectrum Disorders and Pervasive Developmental Disorders – refers to a wide continuum of associated cognitive and neuro-behavioral disorders characterized by, but not limited to, three core defining features: impairments in reciprocal social interactions, impairments in verbal and nonverbal communication, and restricted and repetitive patterns of behaviors or interests. There is marked variability in the severity and complexity of symptomatology across individuals as well as intellectual functioning that can range from profound mental retardation to the superior level of cognitive ability.

  - Autistic Disorder
  - Pervasive Developmental Disorder Not otherwise Specified
  - Asperger's Disorder
  - Rett's Syndrome (Rett's Disorder)
  - Childhood Disintegrative Disorder

- Mental Retardation – refers to significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning (e.g., communication, self-care, home living, social or interpersonal skills, use of community resources, functional academic skills, work, leisure, health and safety). The severity of mental retardation and level of adaptive functioning varies given the degree of a child's impairment:[12]

  - Mild Mental Retardation IQ level 50 – 70
  - Moderate Mental Retardation IQ level 35 – 50
  - Severe Mental Retardation IQ level 20 – 35
  - Profound Mental Retardation IQ level below 20

- Psychiatric and Behavioral Disorders – refer to children and adolescents with a range of conditions, which result in impaired or compromised levels of functioning across various domains.

  - Attention Deficit Hyperactivity Disorder

[12] Developmental Disability means a severe, chronic disability, other than mental illness, which: a) is attributable to a cognitive or physical impairment or combination of cognitive and physical impairments, b) is manifested before the person attains age 22, and c) is likely to continue indefinitely (MHRH Final Regulations, December 21, 1995).

- Conduct Disorder
- Intermittent Explosive Disorder
- Opposition Defiant Disorder
- Tourette's Disorder
- Mood Disorders (e.g., Depression and Bipolar Disorders)
- Anxiety Disorders (e.g., Panic Disorder, Post Traumatic Stress Disorder, Generalized Anxiety Disorder, Obsessive – Compulsive Disorder, and Social Phobia)
- Psychotic Disorders (e.g., Schizophrenic Conditions, Delusional Disorder, or Brief Psychotic Disorder)

- General Medical and Physical Conditions – refers to a wide range of conditions with complex genetic, metabolic and/or neurological factors that significantly effect a child's functioning. Some of these conditions are:

  - Angelman's Syndrome
  - Cerebral Palsy
  - Duchenne's Muscular Dystrophy
  - Klinefelters Syndrome
  - Landau-Kleffner Syndrome
  - Prader Willi Syndrome
  - Tuberous Sclerosis

APPENDIX 6: PROVIDER-AGENCY RESPONSIBILITY FOR MONITORING MEDICAID ELIGIBILITY

A recipient's eligibility to receive Medicaid can change at any time. It is the responsibility of the HBTS provider to verify eligibility. This can be accomplished by contacting the Recipient Eligibility Verification System (REVS) 784-8100.

Loss of Medicaid coverage results in nonpayment of claims. Providers may request retroactive reimbursement from EDS once Medicaid coverage has resumed if the child is retroactively reinstated and there has been no lapse in coverage, and if the child has had an approved Treatment plan.

APPENDIX 7: TREATMENT SUPPORT DOMAINS

With the development of new services for children with special health care needs, such as Personal Assistance Services and Supports (PASS), the degree to which treatment support is utilized may change**.** The following gives guidance to help understand the purpose of Treatment Support as a service that provides structure, guidance, redirection and supervision to a child. The following components help to distinguish this service from Respite. As part of an overall Treatment Plan, Treatment Support is a complement to Specialized Treatment.

Acquiring and Using Information: Is the application or use of information a child has learned. It involves being able to perceive relationships, reason, and make logical choices. Individuals think in different ways. Some children think in pictures, that is, they may solve a problem by watching and imitating what another person does. For others, thinking involves using language to understand others as well as to express oneself. Related tasks could involve:

- Learning to read, write, do arithmetic and understand new information
- Follow directions and instructions
- Ask for information
- Explain something
- Communicate basic information – name, address, telephone number, yes/no, take/give messages, make requests, and express functional needs (e.g., toileting, drink, food, etc.)
- Learning to take a bus
- Shopping

Attending and Completing Tasks: Involves directing and sustaining attention while engaged in an activity or task. This means focusing long enough to begin and complete an activity and being able to return to it if distracted. Related tasks could involve:

- Attends to directions and instructions
- Listens and attends to what others are saying
- Remains at a designated task or activity for a specified time

Interacting and Relating to Others: Involves participating with one's family and others for practical and social purposes. Interactions and relating require a child to respond to a variety of emotional and behavioral cues. Speaking intelligently and fluently, turn taking, responding to authority, and understanding another person's feelings form the foundation of social interactions. Related tasks could involve:

- Playing games and turn taking
- Developing and using manners while in the community or at home
- Using appropriate language

- Joining community activities
- Helping others

Caring for Your Self: Caring for one's self is important to a child's sense of mastery and development of competence. It involves engaging in self-care activities as independently as possible for physical, developmental and emotional needs. Related tasks could involve:

- Hygiene activities
- Grooming
- Arranging, preparing meals, and eating meals
- Doing laundry
- Selecting clothes and dressing

Maintaining Health and Physical Well-being: Involves developing an understanding of daily habits that are necessary to good health. For a child, this means learning to recognize healthy practices as well as having time to engage in meaningful recreation. Related tasks could involve:

- Outdoor activities
- A schedule of physical exercise
- Participating in after school sports
- Movement exercises
- Media activities – computer, television, and video games

APPENDIX 8: FACTORS RELATED TO TREATMENT INTENSITY FOR HBTS SPECIALIZED TREATMENT

Children with behavioral and/or developmental conditions learn in complex ways with unique learning styles. They demonstrate highly individualized differences in cognitive and affective processes, language, motor, visual, auditory, spatial, and relationship capacities.

Some professionally recognized interventions include:

- Applied Behavior Analysis (ABA)
- ABA Discrete Trial Teaching
- Developmental – Social Interventions including communication therapies and the Developmental, Individual Difference, Relationship-based approach (DIR)
- Educational models exemplified by TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children)

RELEVANT TERMINOLOGY

Applied Behavior Analysis (ABA):

Refers to a program of systematic analysis and tracking of behavior including its cues and consequences (i.e., reinforcement).

ABA Discrete Trial Teaching:

This is a rigorous form of behavioral intervention that is time intensive, highly structured, uses repetitive sequences, contingent reinforcement, and requires extensive collection and analysis of data.

Developmental, Individual Difference, Relationship-Based Approach (DIR):

A comprehensive model proposed by the Interdisciplinary Council of Developmental and Learning Disorders that focuses on the functional developmental capacities, individual differences and relationship interactions when assessing a child.

Developmental-Social Pragmatic Instruction:

A model of intervention that includes aspects of behavior theory, language development and social-communicative functions. Strategies typically involve imitation, solitary play, group play, social skills training, use of social stories, incidental or experiential learning opportunities, and various communication modalities (e.g., picture exchange communication system, language board, or Bliss symbols).

TEACCH:

TEACCH uses educational and visual communication strategies to establish routines and to reduce frustration. This approach seems to be especially helpful when language is very delayed.

APPENDIX 9: PARENT PARTICIPATION IN HBTS

Parent participation in the development of a child's HBTS Treatment Plan is required. Parent or guardian approval of all Treatment Plans – initial, revised, and renewal requests for continuing HBTS – is required also. Treatment Plans must contain a parent or guardian's signature. It is recommended that provider-agencies create a separate page that includes a statement indicating that the parent has participated in the development of the plan, reviewed it, and supports the plan. The parent or guardian shall sign this page and it must be included in the proposal.

A child's parent or guardian is expected to be present when home-based therapy is being provided. At other times, it may be appropriate for the home-based worker to work with a child alone and/or participate in community-based activities necessary to accomplish defined therapeutic objectives.

For families involved with DCYF and having a case plan, provider-agencies must consult and coordinate all aspects of a child's HBTS plan to insure compliance with DCYF mandates or expectations for a family under its care.

APPENDIX 10: PROVIDER-AGENCY RESPONSIBILITIES FOR DISCONTINUATION OF HBTS

DHS recognizes that there may be critical situations whereby continued HBTS becomes compromised or clinically inappropriate, necessitating suspension or discontinuation of care. These can include, but are not limited to, risks to the safety and welfare of the child, family or home based worker, and treatment non-compliance. As such, the HBTS provider-agency has responsibility to exercise prudent judgment and prevent abandonment of care when responding to crisis situations. The following guidelines are to be followed:

1) Parental participation in the development and application of a child's HBTS Treatment Plan is an ongoing process whereby critical situations or circumstances are identified and addressed.

2) Written documentation regarding critical treatment concerns is required and will identify risks and actions to be taken to reduce or eliminate further recurrence of problem situations. A copy is to be maintained as part of the child's Treatment Plan. Possible responses may involve modifications to the authorized Treatment Plan, including referrals for emergency psychiatric evaluation, hospitalization, individual or family therapies, DCYF services, or other actions (e.g., reassessing treatment intensity, treatment objectives, treatment methods, etc.,).

3) When multiple efforts to resolve difficulties (including lack of participation in treatment by parents or guardians) have failed and are documented, the provider-agency can initiate discontinuing HBTS, namely:

    a) The child's family or guardian as well as DHS or CEDARR Family Center must receive written notification 30 days prior to discontinuing HBTS. Reasons for discontinuing treatment must be stated. Alternative resources, and/or referrals if appropriate, must be given.

    b) All other providers and professionals related to the HBTS plan must receive written notice.

4) DHS recognizes that provider-agencies may need to remove a home-based worker immediately when confronted with sexual harassment, threats of violence, verbal abuse, assault or health risks (e.g., individual who is substance impaired). As such, it may be inappropriate to resume HBTS, if at all, until circumstances have been fully resolved to the satisfaction of the HBTS provider-agency. DHS or CEDARR Family Center must receive immediate written notification when such situations develop, and be fully informed regarding problem resolution, which could include immediate suspension or termination of HBTS.

    a) If immediate termination is indicated, the provider-agency has the responsibility to also notify DCYF when issues of child neglect or abuse are suspected.

b) Parents or guardians should also be informed about how to obtain emergency psychiatric services (e.g., contacting the police or local community mental health center) for immediate assistance.

5) A parent or guardian has the right to terminate HBTS at any time during an authorized course of care. The provider-agency must have written policies to facilitate an orderly transition of care, and/or follow-up or referral services, and communicate with the CEDARR Family Center or DHS.

APPENDIX 11: APPEAL RIGHTS – RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

APPEAL RIGHTS – READ CAREFULLY

You have a right to discuss this action further with me or my supervisor, or to request an adjustment conference with the appropriate DHS Supervisor. **If you have questions regarding this notice, call the Agency representative at the telephone number listed on the first page of the notice.**

You have the right to request and receive a hearing if you disagree with the decision made regarding the level or length of services, in the approved treatment plan. You must request a hearing in writing within thirty (30) days of this notice.

If you request a hearing regarding your medical services within ten (10) days of this notice, you will continue to received the current amount of Medical Assistance Services until a hearing decision is made.

The form to request a hearing is enclosed. If you request a hearing you may represent yourself or authorize another person, such as a relative or legal counsel to represent you. Free legal help may be available by calling Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

EXCEPTION: If this action implements a hearing decision, you may not have the right to another hearing on this action. See the hearing decision letter for your right for judicial review in accordance with Rhode Island law (42-35-1 et seq.).

TO REQUEST A HEARING

All requests must be in writing. To request a hearing, complete Section I., the 'Statement of Complaint' on the REQUEST FOR A HEARING form or else submit your complaint in writing. Briefly describe the Agency action you wish to appeal. You can fill out the form yourself, or with the help of the Agency representative if you need help in completing the form. The form is signed by the person to whom the notice is addressed or her/his representative.

Mail or bring the hearing request form to the Center for Child and Family Health, Department of Hunan Services Forand Building, 600 New London Avenue, Cranston, RI 02920. In order to receive a hearing, you must do so within the time periods specified on this page. You will be notified of the time and place of the hearing. At the same time, you will also receive a statement of the Agency's position, an explanation of the policy on which the decision was based, and additional information about the hearing process.

INFORMATION ABOUT HEARINGS FOR APPLICANTS AND RECIPIENTS OF FINANCIAL ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SOCIAL SERVICES

The Department of Human Services (DHS has a responsibility to provide financial assistance, food stamps, medical assistance, and social services to individuals and families for whom eligibility is determined under the provisions of the Social Security Act, the Rhode Island Public Assistance Act, the Food Stamp Act, the Rhode Island Medical Assistance Act and Title XCX Social Services.

The hearing process is intended to insure and protect your right to assistance and your right to have staff decisions reviewed when you are dissatisfied. You have asked for a hearing because of an agency decision with which you disagree. The following information is sent to help you prepare for your hearing and to inform you about what you may expect and what will be expected of you when it is held.

1. WHAT IS A HEARING?

A hearing is an opportunity provided by the Department of Human Services to applicants or recipients who are dissatisfied with a decision of the agency, or a delay in such a decision for a review before an impartial appeals officer to insure correct application of the law and agency administrative policies and standards.

2. WHO CONDUCTS A HEARING?

A hearing is conducted by an impartial appeals officer appointed by the Director of the Department of Human Services to review the issue(s) and give a binding decision in the name of the Department of Human Services,

3. WHO MAY ATTEND A HEARING?

A hearing is attended only by persons who are directly concerned with the issue(s) involved. You may be represented by legal counsel if you chose and another witness or a relative or friend who can speak on your behalf. The Agency is usually represented by the staff member involved in the decision and/or that worker's supervisor. Legal services are available to persons wishing to be represented by legal counsel through Rhode Island Legal Services (274-2652) or (1-800-662-0534).

If an individual chooses to have legal representation, e.g. be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. **It** is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

4. WHERE IS THE HEARING HELD?

The hearing may be held at a regional or district office or in an individual's home when circumstances require.

5. HOW CAN YOU LEARN ABOUT THE DEPARTMENT'S RULES AND REGULATIONS?

Section III of the attached form (DHS-121) shows the policy manual references, which are at issue in your hearing. You may review the Department's regulations at any local welfare office during regular business hours.

You may also review the Department's hearing decisions rendered on or after April 1987. They are available only at the DHS Central Administration Building, 600 New London Avenue, Cranston Rhode Island, between the hours of9:00 a.m. and II :00 a.m. and between the hours of 1 :00 p.m. and 3:00 p.m. Monday through Friday.

6. WHAT ARE YOUR RIGHTS RELATIVE TO THE HEARING?

You have a right to examine all documents and records to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing.

You may present your case **in** any way you wish without undue interference, by explaining the situation yourself or by having a friend, relative, or legal counsel speak for you, and you may bring witnesses and submit evidence as discussed above to support your case. You will have an opportunity to question or refute any testimony or evidence and to confront and cross-examine adverse witnesses.

7. HOW IS A HEARING CONDUCTED?

A hearing differs from a formal court procedure because you are not on trial and the appeals officer is not a judge in the courtroom sense. However, any person who testifies will be sworn in by the appeals officer.

After you have presented your case, the staff member will explain the provisions in law or agency policy under which s/he acted. When both sides have been heard, there will be open discussion under the leadership and guidance of the appeals officer. The entire hearing is recorded on tape.

8. HOW WILL THE HEARING DECISION BE MADE?

The tape recording of the testimony of the persons who participated in the hearing, together with all papers and documents introduced at the hearing, will be the basis for the decision.

The appeals process is generally completed within 30 days of the receipt of your request, but will never exceed sixty (60) days for food stamps and ninety (90) days for all other programs unless you request a delay, in writing, to prepare your case.

The appeals officer will inform you of her/his findings, in writing, following the hearing. If you are still dissatisfied, you have a right to judicial review of your case. The agency staff member wants to be as helpful as possible in assisting you to prepare for the hearing. If you have any questions about what you may expect, or what may be expected of you, be assured that you may call your eligibility technician or worker.

APPENDIX 12: EXAMPLES OF GLOBAL ASSESSMENT SCALES

GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE

RANGE	DESCRIPTION
100 – 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 – 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than every day problems or concerns (e.g., an occasional argument with family members).
80 – 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
70 – 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 – 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50- 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 – 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, is unable to work; child frequently beats up younger children; is defiant at home, and is failing in school).
30 – 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).
21 – 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 – 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

From: American Psychological Association DSM - IV

Adaptation - CHILDREN'S GLOBAL ASSESSMENT SCALE (4 Through 16 years)

Rate the subject's level of functioning in the last 3 months by selecting the level which describes his/her functioning on a hypothetical continuum of mental health illness. For example, a subject who exhibits "difficulties…previously differentiation of reality and fantasy" (level 30) should be noted at that level even though he/she has "major impairment in functioning…" (Level 40). Rate actual functioning independent of whether or not subject is receiving and may be helped by treatment or has previously shown better or worse functioning (i.e., history).

Range	Description
100 - 90	Superior functioning in many areas, good function in all areas.
89 – 80	Good functioning in all areas. Fundamentally secure in family, school and with peers so that situational responses are transitory, non-symptomatic (i.e., acknowledged and managed by the child), and do not interfere with functioning.
79 - 70	Slight interference with functioning in family, school or with peers. Health responses to situational crisis may produce symptoms, but symptoms are minimal, brief and only slightly interfere with functioning.
69 - 60	Some difficulty in functioning in family, school, or with peers due to normal responses to developmental crisis (e.g., age-appropriate phobia, separation anxiety), but these symptoms do not seriously impair functioning. The symptomatic behavior would ne be sufficiently intense to label the child as disturbed.
59 - 50	Moderate difficulty in functioning in family, school, or with peers due to mild symptoms (mild adjustment reactions, reactive disturbance, mild peer relationship problems, mild psychosomatic problems, mild habit or conduct disturbances, bed wetting, neurotic traits). Functioning may be constricted, but still appropriate.
49 – 40	Clear interference in functioning in family, school, or with peers due to serious impairments in personality development (e.g., personality disorders, oppositional child, impulsive-ridden child, poorly socialized child). Most clinicians would agree that these symptoms represent disturbance.
39 - 30	Major impairment in functioning in family, school, or with peers due to sever symptoms (e.g., psychoneurotic disorders, severe behavior disorders, withdrawal aggression, hyperactivity, severe or persistent psychosomatic complaints, recurrent destructive or self-destructive behavior, compulsiveness, obsessions, severe or frequent anxiety).
29 – 21	Unable to function in some but not all areas in family, school, or with peers due to gross disruption in behavior or difficulties in object relations or in differentiation of reality and fantasy.
20 - 19	Needs almost constant supervision due to severely destructive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, object relations or personal hygiene.
10 - below	Needs constant supervision (24 hour care) due to severely destructive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, object relations or personal hygiene.

Autistic, symbiotic, psychotic, or borderline children may appear anywhere from 1 to 30 on this scale, depending on ability to function.

Reference: David Shaffer, Division of Child and Adolescent Psychiatry, Columbia University, New York Psychiatric Institute, 722 West 168th Street, Unit 78, New York, NY 10032

APPENDIX 13: DESCRIPTIONS OF ACCREDITATION ABBREVIATIONS

COA	**Council On Accreditation**
CARF	**Commission On Accreditation Of Rehab Facilities**
CORF	**Comprehensive Outpatient Rehab Facility**
DCYF	**Department Of Children Youth And Families**
DOE	**Department Of Education**
DOH	**Department Of Health**
DOL	**Department Of Labor**
JCAHO	**Joint Commission On Accreditation Of Health care Organizations**
MHRH-DD	**Mental Health Retardation Hospitals – Dev. Disabilities**
ORS	**Office Of Rehab Services**

APPENDIX 14: GUIDELINES FOR CONSUMERS OF APPLIED BEHAVIOR ANALYSIS SERVICES TO INDIVIDUALS WITH AUTISM

Autism Special Interest Group (SIG), Association for Behavior Analysis
Adopted May 23, 1998

The Autism Special Interest Group (SIG) of the Association for Behavior Analysis believes that all children and adults with autism and related disorders have the right to effective education and treatment based on the best available scientific evidence. Research has clearly documented the effectiveness of Applied Behavior Analysis (ABA) methods in the education and treatment of people with autism. Planning, directing, and supervising effective ABA programs for people with autism requires specific competencies. Individuals with autism, their families, and other consumers have the right to know whether persons who claim to be qualified to direct ABA programs actually have the necessary competencies. Consumers also have the right to hold those individuals accountable for providing quality services, i.e., to ask them to show how they use objective data to plan, implement, and evaluate the effectiveness of the interventions they use.

Formal credentialing of professional behavior analysts (i.e., registration, certification, or licensure) can provide safeguards for consumers, including means of screening potential providers and some recourse if incompetent or unethical practices are encountered. At present, however, procedures for credentialing professional behavior analysts are in place in only a few states. Until they are implemented more widely, the Autism SIG recommends that consumers seek to determine if those who claim to be qualified to direct ABA programs for people with autism meet the following minimum standards:

I. The qualifications embodied in the standards for certification as a behavior analyst in the State of Florida, Department of Children and Families, which can be summarized as follows[13]:

Formal training

- Master's or doctorate in behavior analysis, or in psychology, special education, or another human service discipline with an emphasis in behavior analysis

- Coursework in principles of learning, principles of behavior, or basic behavior analysis; experimental analysis of behavior; behavioral assessment or methods of direct observation of behavior; applied behavior analysis; single-subject research designs; legal and ethical Issues

- Supervised practicum, internship, or employment experiences in applied behavior analysis

[13] For details, see "Identifying qualified professionals in behavior analysis" by G.L. Shook & J.E. Favell in *Behavioral Intervention for Young Children with Autism*, edited by C. Maurice, G. Green, & S.C. Luce; Austin, TX: PRO-ED, 1996; and "Essential content for training behavior analysis practitioners," by G. L. Shook, F. Hartsfield, & M. Hemingway, *The Behavior Analyst,* 1996, Vol. 18, pp. 83-91

Competencies

- Ethical considerations
- Definition and characteristics of applied behavior analysis
- Basic principles of behavior
- Descriptive analysis
- Demonstrating functional relations
- Measurement of behavior
- Data display and interpretation
- Selection of target behaviors and goals
- Behavior change procedures
- Generalization and maintenance of behavior change
- Managing emergencies
- Transfer of technology
- Support for behavior analysis services

II. Additional training and experience in directing and supervising ABA programs for individuals with autism:

- Formal training and/or self-study to develop knowledge of the best available scientific evidence about the characteristics of autism and related disorders, and implications of those characteristics for designing and implementing educational and treatment programs, including their impact on family and community life.

- Formal training and/or self-study to develop knowledge of at least one curriculum consisting of:
    - scope and sequence of skills based on normal developmental milestones, broken down into component skills based on research on teaching individuals with autism and related disorders;
    - prototype programs for teaching each skill in the curriculum, using behavioral methods;
    - data recording and tracking systems; and
    - accompanying materials.

- At least one full calendar year (full time equivalent or 1000 clock hours [@ 25 hrs/wk for 40 weeks]) of hands-on training in providing ABA services directly to children and/or adults with autism under the supervision of a behavior analyst with a master's or doctorate and at least 5 years' experience in ABA programming for individuals with autism. The training experience should include at a minimum:

a. Provision of AHA programming to at least 5 individuals with autism.

b. Designing and implementing individualized programs to build skills in each of the following areas: "learning to learn" (e.g., observing, listening, following instructions, imitating); communication (vocal and nonvocal); social interaction; self-care; academics; school readiness; self-preservation; motor; play and leisure; community living; work.

c. Using both discrete-trial and incidental or "naturalistic" teaching methods to promote skill acquisition and generalization.

d. Incorporating the following into skill-building programs: prompting; error correction; discrimination training; reinforcement strategies; strategies for enhancing generalization.

e. Modifying instructional programs based on frequent, systematic evaluation of direct observational data.

f. Designing and implementing programs to reduce stereotypic, disruptive, and destructive behavior based on systematic analysis of the variables that cause and maintain the behavior .

g. Incorporating differential reinforcement of appropriate alternative responses into behavior reduction programs, based on the best available research evidence

h. Modifying behavior reduction programs based on frequent, systematic evaluation of direct observational data.

i. Provision of training in ABA methods and other support services to the families of at least 5 individuals with autism.

j. Provision of training and supervision (at least I hour of supervision per 10 hours of client contact for at least one-half of the training period) to at least 5 professionals, paraprofessionals, or college students providing ABA services to individuals with autism.

The Autism SIG urges consumers to ask prospective directors or supervisors of ABA services to provide documentation of their qualifications in the form of: membership in the Association for Behavior Analysis; degrees; letters of reference from employment supervisors and/or families for whom they have directed ABA programming for similar individuals with autism (with appropriate safeguards for privacy and confidentiality); any registration, certificate, or license in Applied Behavior Analysis *per se* (i.e. , not psychology, special education, education, or another discipline with no emphasis in behavior analysis); results of any competency exams they may have taken in Applied Behavior Analysis; participation in professional meetings and conferences in behavior analysis; publications of behavior analytic research in professional journals. *A few workshops, courses, or brief hands-on experiences do not qualify one to practice Applied Behavior Analysis effectively and ethically.*

DISCLAIMER: This document suggests guidelines for consumers to use in determining who is qualified to direct Applied Behavior Analysis programs for individuals with autism, as recommended by the Autism Special Interest Group of the Association for Behavior Analysis.

APPENDIX 15: DOCUMENTATION GUIDELINES FOR HBTS

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
Center for Child and Family Health
October 2000

Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

Home Based Therapeutic Service Providers

I. Documentation Requirements

A. Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to children receiving HBTS. Providers must furnish to DHS and/or the Medicaid Fraud Control Unit of the Attorney General's Office such records and any other information regarding payments for claimed or services rendered that may be requested. These guidelines are applicable to all children receiving home–based services authorized by DHS.

Documentation – The Basics

The following are the basic principles of documentation. They apply to all types of services in all settings (i.e., Specialized Treatment, Treatment Support, Clinical Supervision, Treatment Consultation and Treatment Coordination).

1. The service/client record should be complete and legible.

2. The documentation of each client/consumer encounter should include or provide reference to:

   a) The reason for the encounter, and as appropriate, relevant history.

   b) Current status.

   c) Written treatment or progress notes including care provided and the setting in which the services were rendered.

   d) Date and time and legible identity/credentials of care provider.

   e) The amount of time it took to deliver the services.

3. The client's progress, response to and changes in treatment and any revision of the Treatment Plan should be documented.

B. A clear trail must be maintained. Each provider is responsible for devising a system that documents those services, which have been provided. This back-up information is usually contained in the client record, daily log, or both and must be sufficiently detailed to show that a client received a specific number of hours of treatment services and that a corresponding number of hours were billed to Medicaid.

C. All Home-Based Therapeutic Services must be provided in accordance with an approved comprehensive treatment program that clearly documents the medical necessity of the services. Treatment Plans must conform with *Guidelines for the Review and Approval of Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Prescription Treatment Plan Proposals* issued, November 1999 by DHS.

D. Methods of Documentation:

1. Information may be coded on a log or worksheet, however, weekly and monthly summaries of the overall relationship of the services to the treatment regimen (goals and objectives) described in the Treatment Plan with and update describing the client's progress and containing the clinician's judgment of the effects of the treatment must be recorded.

2. The client's progress and current status in meeting the goals and objectives of his or her Treatment Plan must be regularly recorded in the client record in the form of progress notes. Progress notes must include:

   a) Documentation of the implementation of the Treatment Plan.

   b) Chronological documentation of the client's clinical course

   c) Significant events and/or changes in the client's condition should be documented with a full narrative note whenever they occur.

   d) Periodic documentation of all treatment provided to the client

   e) Descriptions of the response of the client to treatment as well as the outcome of treatment.

3. A discharge summary must be entered into the client record within a reasonable period of time after discharge. The Discharge Summary must include:

   a) Significant findings including final primary and secondary diagnoses.

b) General observations about the client's condition initially, during treatment and at discharge.

c) Whether the discharge was planned or unplanned and, if unplanned, the circumstances.

d) Assessment of attainment of the Treatment Plan objectives.

e) Documentation of referral to other appropriate program or agency.

II. Monitoring and Quality Assurance

Site visits will be conducted by DHS staff to monitor appropriate use of Medicaid services and compliance with the procedures outlined in this manual. During these visits, staff will review the following:

1.) Client records and Treatment Plans
2.) Staff orientation programs and attendance logs
3.) Agency policy and procedures related to HBTS service provision
4.) Claims information/documentation
5.) Staff time sheets
6.) Complaint log

Providers will be notified of DHS site visits in advance if possible. Unannounced site visits may also be conducted at the discretion of the Department. DHS staff may contact or visit families as part of the oversight and monitoring activities.

In the event of adverse findings of a minor nature, repayment to DHS will be required. In situations where, in the opinion of the Department, significant irregularities in billing or utilization are revealed, providers may be required to do a complete self-audit in addition to making repayments. In either case, technical assistance in developing and implementing a plan of corrective action, where appropriate and applicable, will be offered to the provider.

In addition to monitoring conducted by DHS, providers are subject to periodic fiscal and program audits by the Health Care Financing Administration.

III. Client Record Guidelines

All Home Based Therapeutic Services must be provided in accordance with a comprehensive Treatment Plan that documents the medical necessity of the services. Treatment Plans for clients for whom providers are billing Medicaid must conform to the following guidelines:

1. Each client shall have a current written, comprehensive, individualized Treatment Plan that is based on assessments of the client's medical/behavioral needs.

2. Responsibility for the overall development and implementation of the Treatment Plan must be assigned to an appropriate member of the professional staff.
3. The Treatment Plan must be reviewed at major decision points in each client's course of treatment including:

   (a) The time of admission and discharge
   (b) A major change in the client's condition
   (c) The point of the estimated length of treatment and thereafter based on the estimated length of treatment, e.g., re-reviews of the Treatment Plan.
   (d) At least every six months of treatment.

5. The Treatment Plan must contain specific goals that the client must achieve and/or maintain as well as maximum growth and adaptive capabilities. These goals must be based on periodic assessments of the client and as appropriate, the client's family.

IV. Supplemental Guidelines:

1. Medicaid is, by definition, a ***medical*** program, which pays for ***medical*** services. A Treatment Plan is regarded as a prescription for services and must be signed by an appropriate professional, in this case, a Licensed Practitioner of the Healing Arts.

2. The diagnosis must clearly be evident in the Treatment Plan and the diagnosis must be considered as the overall plan is developed. There must be a clear connection between the diagnosis and the symptoms of the condition for which the client is being referred.

3. The reasons for, and the amount and duration of each specific intervention should be evident in the plan.

4. Progress notes should reflect a judgment being made be the provider regarding the results of the treatment rendered, i.e., an assessment of why the interventions prescribed are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done.

APPENDIX 16: CEDARR FAMILY CENTERS

1. **About Families**
   CEDARR Family Center
   32 Branch Avenue
   Providence, RI 02904

   401-621-2200

2. **Families First CEDARR**
   Hasbro Children's Hospital
   593 Eddy Street, Room 120
   Providence, RI 02903

   401-444-7703

3. **Family Solutions CEDARR**
   134 Thurbers Avenue, Suite 102
   Providence, RI 02905

   401-461-3251

4. **Easter Seals CEDARR Family Center**
   5Woodruff Avenue
   Narragansett, RO 02882

   401-284-1000

Note: Additional CEDARR Family Centers may be certified periodically.

APPENDIX 17 – SERVICE MONITORING AND REPORTING REQUIREMENTS

Quarterly Report Protocol

Report 1: <u>Provision of authorized direct service hours</u>

Step 1. Identify all treatment plans with an expiration date in the reporting period (e.g., January 1 – March 31, 2003.)

Step 2. Log the client's name, client MID, date the treatment plan started, and date of treatment plan expiration in columns 1 – 4 on the Report 1 Worksheet.

Step 3. For each expiring treatment plan, sum the number of direct service hours authorized for the entire treatment plan authorization period (e.g., for a plan expiring on January 31, 2003, the treatment plan authorization period could be August 1, 2002 – January 31, 2003) and enter the number of authorized hours in column 5 on the Report 1 Worksheet.

Step 4. For each expiring treatment plan, sum the number of direct service hours provided during the entire treatment plan authorization period and log the number of hours provided in column 6 on the Report 1 Worksheet.

Step 5. For each client identified divide the sum of provided hours by the sum of the authorized hours (column 6/column 5) and enter that percentage into column 7.

Step 6. If the percentage of authorized hours provided (column 7) is at least 75%, enter "yes" on column 9, meets standard. If column 7 is less than 75%, enter "no" on column 9, meets standard.

Step 7. Count the number of treatment plans for which meet the standard of at least 75% of authorized hours are provided ("yes"'s in column 9)

Step 8. Divide the number of "yes"s in column 9 by the total number of treatment plans with an expiration date in the reporting period. (number of plans meeting standard – yes's from column 9/total number of treatment plans with an expiration date in the reporting period)

Step 9. Report the percent from step 8 on the Quarterly Report sheet, in the row labeled Report 1, Provision of authorized direct service hours.

Report 2: Timeliness of intake appointments

Step 1. Identify all new clients who had an initial intake appointment during the reporting period (e.g., January 1, 2003 – March 31, 2003.)

Step 2. Log the client's name, client MID, date the referral, and date of the intake appointment in columns 1 – 4 on the Report 2 Worksheet.

Step 3. Calculate the number of days between the date of the referral (column 3) and the date of the initial intake appointment (column 4) and enter that number into column 5, days from referral to intake.

Step 4. If the number of days between treatment referral and intake appointment (column 5) is ≤ 21 days, enter "yes" into column 7, meets intake appointment standard. If the number of days in greater than 21, enter "no" into column 7.

Step 5. Count the number of "yes"s in column 7.

Step 6. Divide the total number of intake appointments taking place within 21 days of written treatment referral by the number of intake appointments taking place within the reporting period to determine if the agency meets the performance standard. (number of plans meeting standard – "yes"'s from column 7/total number of intake appointments taking place in the reporting period)

Step 7. Report the percentage from Step 6 on the Quarterly Report sheet, in the row labeled Report 2, Timeliness of intake appointments.

Report 3: Timeliness of new treatment plan submissions

Step 1. Identify all treatment plans that were submitted for authorization during the reporting period.(e.g., January 1, 2003 – March 31, 2003.)

Step 2. Log the client's name, client MID, the date of the intake appointment, and the date the treatment plan was submitted to CEDARR Family Center for authorization in columns 1 – 4 on the Report 3 Worksheet.

Step 3. Calculate the number of days between the date of intake appointment (column 3) and the date the treatment plan was submitted to the CEDARR Family Center for authorization (column 4), and enter that number in column 5.

Step 4. If the number of days between the intake appointment and the date the treatment plan was submitted for authorization (column 5) is ≤ 28 days, enter "yes" in column 7, meets treatment plan submission standard. If the number of days is greater than 28, enter "no" in column 7.

Step 5. Count the number of "yes"s in column 7.

Step 6. Divide the number of treatment plans submitted for authorization within 28 days of intake appointment by the total number of treatment plans that were submitted for authorization during the reporting period to determine if the provider agency meets the performance standard (number of plans meeting standard – "yes"'s from column 7/total number of treatment plans submitted for authorization in the reporting period)

Step 7. Report the percentage from Step 6 on the Quarterly Report sheet, in the row labeled Report 3, Timeliness of new treatment plan submission.

Report 4: Timeliness of direct service initiation for new clients

Step 1. Identify all new clients who had direct services initiate during the reporting period (e.g., January 1, 2003 and March 31, 2003)

Step 2., Log the client's name, client MID, the date of receipt of treatment plan authorization, and date of the initiation of direct services (first date for which direct services are billed) in columns 1 – 4 on the Report 4 Worksheet.

Step 3. Calculate the number of days between the date the treatment plan authorization was received from the CEDARR Family Center (column 3) and the date of direct service initiation (column 4), and enter that number into column 5, timeliness of initiation of services.

Step 4. If the number of days between receipt of authorization from the CEDARR Family Center and the initiation of direct service (column 5) is $\leq$ 21 days, then enter "yes" in column 7, timeliness of initiation of direct services. If the number of days is greater than 21, enter "no" in column 7.

Step 5. Count the number of "yes"s in column 7.

Step 6. Divide the total number of clients for whom direct services were initiated within 21 days of receipt of treatment plan authorization by the number of clients for whom services were initiated during the reporting period to determine if the provider agency meets the performance standard (number of plans meeting standard – "yes"s from column 7/total number of treatment plans for which services were initiated in the reporting period)

Step 7. Report the percentage from Step 6 , on the Quarterly Report sheet, in the row labeled Report 4, Timeliness of direct service initiation for new clients.

Report 5: Timeliness of renewing treatment plan submissions

Step 1. Identify all renewing treatment plans that were submitted to DHS or CEDARR Family Center for reauthorization during the reporting period (e.g., treatment plan submission for reauthorization date falls between January 1, 2003 and March 31, 2003

Step 2. Log the client's name, client's MID, date expiring treatment plan authorization expires, and the date the plan was submitted for reauthorization in columns 1 – 4 of the Report 5 Worksheet.

Step 3. Calculate the number of days between the date the renewing treatment plan was submitted for reauthorization (column 4 and the expiring treatment plan expiration date (column 3) and enter that number into column 5, days prior to treatment plan expiration that plan was submitted for reauthorization.

Step 4. If the number of days between treatment plan submission for reauthorization and treatment plan expiration (column 5) is $\geq$ 30, then enter "yes" into column 7, meets standard. If the number of days is less than 30, then enter "no" into column 7.

Step 5. Count the number of "yes"s in column 7.

Step 6. Divide the total number of treatment plans submitted for reauthorization at least 30 days prior to treatment plan expiration by the total number of treatment plans submitted for reauthorization in the reporting period to determine if the agency meets the performance standard. (number of plans meeting standard – yes's from column 8/total number of treatment plans submitted for reauthorization in the reporting period)

Step 7. Report the percentage from Step 6 , on the Quarterly Report sheet in the row labeled Report 5, Timeliness of renewing treatment plan submissions.

The Quarterly Report coversheet and Report Worksheets, are attached in Appendix 17. In addition, data entry logs have been created and attached to facilitate the capturing of data elements necessary in fulfilling the reporting requirements.

Please submit reports on a quarterly basis using the attached Quarterly Reporting Form to:

Anne M. Roach, RN, MEd,
Consultant Public Health Nurse
Center for Child and Family Health
Rhode Island Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920